

the



Canadian Nurse



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HIGHLIGHTS

VOLUME 58

NUMBER 2

MONTREAL

FEBRUARY, 1962

- CHURCH — Evaluation of Nursing Service Personnel
- GILCHRIST — Performance Evaluation in Nursing Service
- WOODWORTH — A Head Nurse's Ideas on Evaluation
- HAYTER — So You Need a Consultant

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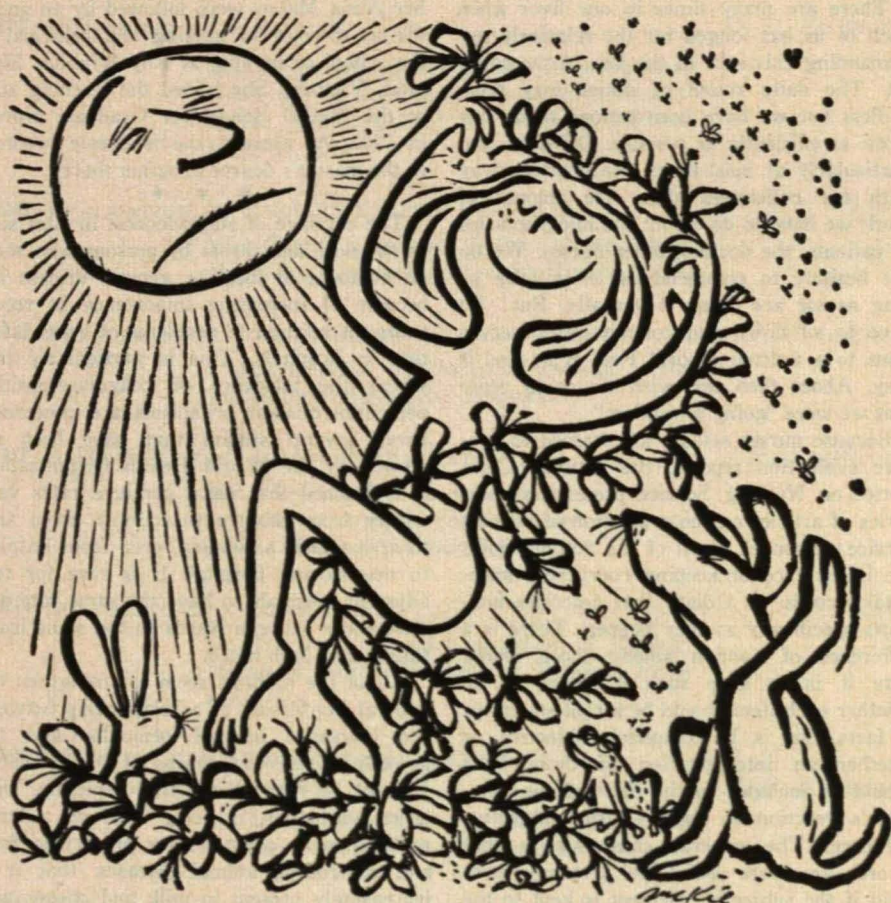


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Between Ourselves

"Where are you going, my pretty maid?"

"I'm going a-milking, sir," she said.

There are many times in our lives when each of us has longed for the relatively undemanding existence of the lass in the couplet. The daily round of duties may seem endless but we have been trained to do our work as efficiently as possible. Off duty, and particularly at meal-times, we chatter away with our colleagues about the amount of work we have to do, about the idiosyncrasies of patients, the doctors, other nurses. We do not hesitate to commend or to criticize so long as we are doing it verbally. But! To have to sit down and commit our observations to a written report! Few of us find it easy. About then, we wish we could reply that we were "going a-milking."

Because nurses seldom are trained to prepare evaluation reports, the national Committee on Nursing Service presents a short series of articles on the evaluation of nursing service personnel. Each of the authors notes the importance of keeping concurrent anecdotal records — a diary that describes incidents specifically as they happen. There is a difference of opinion among those whose duty it is to keep such a record as to whether each item should be a cold statement of facts, that is, be completely objective, or whether an interpretation of those facts should be included in the light of the notetaker's reaction to them — the subjective influence. The general consensus is that records are more useful and certainly more valid if the subjective element is kept to the minimum.

How can nurses learn to keep accurate, useful anecdotal records? A notebook or cards where daily entries can be made will be necessary. Each entry should bear a date and, if more than one person — the head nurse, her assistant, the clinical supervisor — is adding her items, each should be initialed. Student nurses could be taught to keep a diary in which they record both the important things they do each day and also the things they neglect to do.

* * *

Our guest editor, MARY RICHMOND, who is chairman of the Committee on Nursing Service, has had broad experience in both

education and service. Several years as an instructor at Vancouver General Hospital, her Alma Mater, were followed by an active life as director of nursing and principal of the school of nursing at Royal Jubilee Hospital, Victoria. She joined the teaching staff of the McGill School for Graduate Nurses in 1960. At present, she is deeply involved in the master's degree program there.

* * *

The carriage of staphylococci in sites such as the nose and throat by persons who show no evidence of local or general disease has become of increasing importance in recent years, in relation to problems of cross infection in hospitals. This is particularly true where the incidence of coagulase-positive penicillin-resistant organisms are concerned. From several studies that have been reviewed by the World Health Organization, it is learned that nasal carriage rates vary widely from country to country, from area to area within a country, even from hospital to neighboring hospital. It is rare for two adjacent hospitals to have the same rate and differences between wards in the same institution have been noted.

All of the findings seem to strengthen the general impression of a relationship between the increased use of penicillin and the growth of resistant strains of staphylococci. It must be remembered that penicillin, with other antibiotics, is being used on a large scale in many countries for preserving food and controlling animal diseases, that it is increasingly present in milk and cheese, and that quite large numbers of hospital workers are intermittently exposed to small concentrations of the antibiotic. These are all factors likely to promote the emergence of resistant strains in man, quite apart from the effects of inadequate or injudicious chemotherapy in clinical practice.

The School of Hygiene of the University of Toronto is currently investigating the problem of cross infection. C. E. BALCOM and H. D. PALMER describe some of the very familiar techniques in the course of a nurse's work that may be responsible for the spread of organisms. Mrs. CAROLINE MARTIN discovered to her sorrow that she was a persistent carrier under certain conditions.

Sign in a village chemist's shop: "Prescriptions dispensed with deadly accuracy."

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Circulation Manager: Winnifred MacLean

Subscription Rates: Canada & Bermuda: 6 months \$1.75; one year, \$3.00; two years, \$5.00.

Student nurses — one year, \$2.00; three years, \$5.00.

U.S.A. & foreign: one year, \$3.50; two years, \$6.00.

Current issue, 35 cents per copy; back issues, 50 cents per copy.

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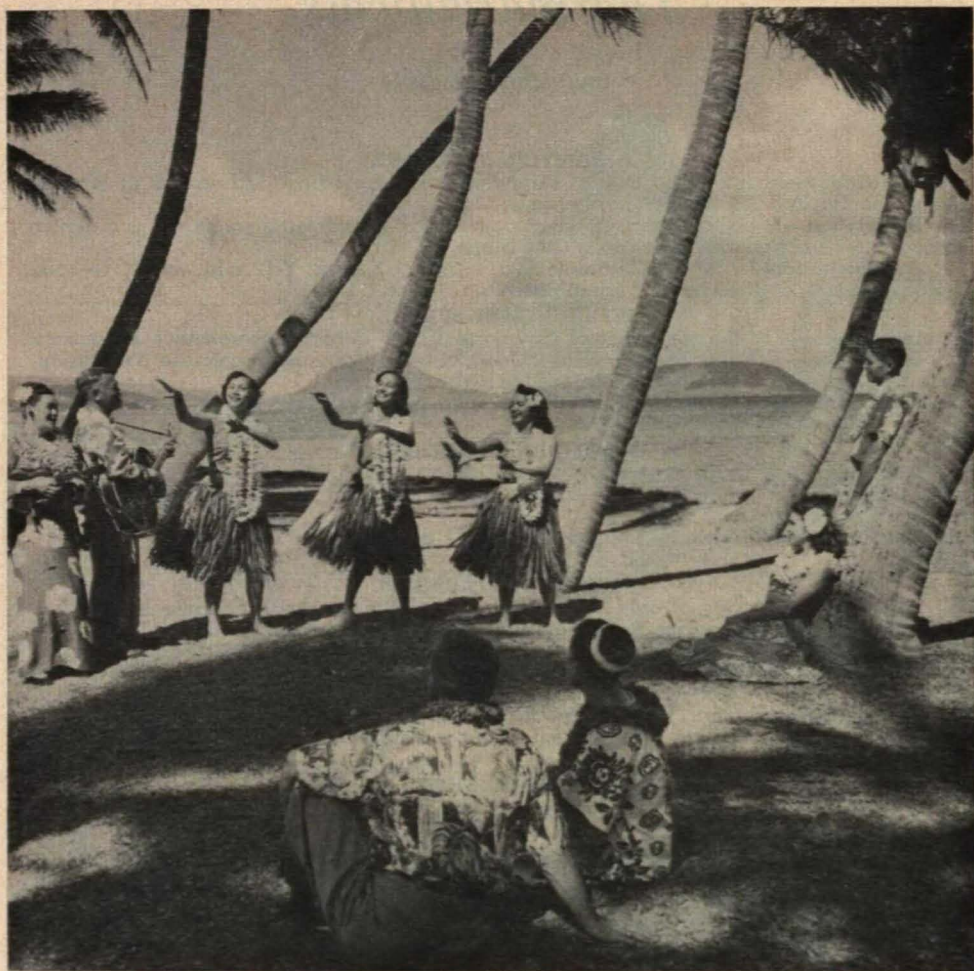
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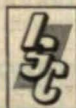
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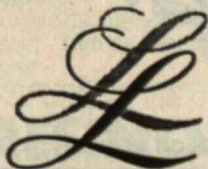
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Dear Editor:

I want to thank you for the many interesting articles that appear in your magazine.

I look forward to receiving it each month and usually read most of it the day it arrives. One of the things that continues to amaze me is the amount of information that I glean about North Carolina and the U.S. Public Health Service that I don't seem to read in other places.

Thanks again for a wonderful magazine.
ELIZABETH WINSTEAD, North Carolina

Dear Editor:

Please send me a reprint of Dr. Watson's Clinical Laboratory Procedures (October, 1960).

I want to congratulate you for your initiative in having this prepared; it is very valuable, and also may I say how much I appreciate the *Journal*.

CARMEN POULIN, Quebec

Dear Editor:

I am the director of the regional office of Social Service in Laprairie and because my wife is a registered nurse I have been able to read the *Journal*.

I have found it very interesting, particularly the October issue. I believe that the director-general of our agency, as well as the directors of our other regional offices, would be most interested in it, too. Would it, therefore, be possible for you to send me six copies of that issue?

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Q: Do Heinz Baby Fruit Juices contain additional quantities of Vitamin C?

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Q: What is the difference between Heinz Strained Baby Foods and Heinz Junior Varieties?

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1. Marks, M.M.: Am. J. Digest. Dis. 18:219, 1951



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THE CANADIAN NURSE

A MONTHLY JOURNAL FOR THE NURSES OF CANADA PUBLISHED
IN ENGLISH AND FRENCH BY THE CANADIAN NURSES' ASSOCIATION

VOLUME 58

NUMBER 2

MONTREAL, FEBRUARY 1962

PERSONNEL EVALUATION

THIS EDITORIAL serves to introduce the articles devoted to the subject of the evaluation of nursing service personnel. These articles have been prepared by three Canadian nurses at the invitation of the Committee on Nursing Service of the Canadian Nurses' Association, which in turn has received many requests from nurses wanting help in this very difficult area.

Some nurses have asked for an evaluation guide, or a printed evaluation form, that might serve as a "national model." Deeper reflection reveals the impossibility of evolving any tool or technique that is capable of such wide use. Perhaps our search for one reflects not so much our belief in its availability, as our frustration at not being able to evolve, within our own work situations, an evaluation form with which we might feel momentarily pleased, let alone permanently satisfied. Yet, a program of employee evaluation must be developed within the framework of each individual institution.

Webster defines the verb "to evaluate," as "to ascertain the value of; to appraise." The question that immediately comes to mind is: "the value for what, and to whom?" Our evalu-



(Chetrons Studio)

MARY RICHMOND

ation of personnel must be preceded by a very clear definition of what we, as an organization, are attempting to do; and a definition, too, of the role of the particular employee within the total purpose of the institution. Clearly, there are times when a plumber is more valuable than a physician! And the question of whether a Jeep or a Jaguar is better is meaningless without a definition or purpose or intent.

The extent to which a service organization fulfills its purpose is undoubtedly due in very large measure to the ability of the individual employee to play her part appropriately within the total program. The kind of person she is, and her sharing of the philosophy and techniques of the particular institution, determine the service she can provide. It is these individual employees who, in aggregate, spell out the success or failure of the institution. Recognizing this and recognizing, too, that evaluation is an important administrative and supervisory duty and responsibility, one still must, within each situation, ask "Why do I want a program of employee evaluation? What do we, here in this hospital, hope to accomplish by it?"

The establishment of criteria and techniques must both, therefore, rest largely with the individual agency. This does not, however, mean that no help is available. Certainly much has been written about evaluation in the fields of educational psychology, industrial relations and personnel management. (No doubt much of our problem in nursing arises from our failure to answer the question of whether we are evaluating students or employees, and to distinguish clearly between the two.) It is, however, not a simple task. It requires the thoughtful effort of supervisory personnel, together with the best available consul-

tation and guidance from experts in the field. It means reading, homework, evening sessions, discussions, trials, failures, printing, and reprinting.

The Committee on Nursing Service has not attempted to meet directly the requests of those who want very specific help. It has arranged for the publication of the following three articles which discuss evaluation, each from a slightly different viewpoint. Miss Jean Church, who teaches in the School of Nursing at Dalhousie University in Halifax, introduces the topic with a general discussion of evaluation. Miss Joan Gilchrist, the director of nursing at the Jewish General Hospital, Montreal, writes of the administrative aspects of an evaluation program. Mrs. Freda Woodworth, a head nurse in the Royal Jubilee Hospital in Victoria, has perhaps the most difficult task — interpreting the evaluation to the employee.

Further suggestions for articles, projects or topics of study will be appreciated by the National Committee, which is made up of the chairmen of the corresponding provincial committees. The full committee meets once a year, in November. The sub-committee meets as necessary. At present, the committee is particularly interested in the study being undertaken in connection with the third recommendation of the Pilot Study, which is concerned with establishing criteria for the evaluation of patient care. Many of the problems of evaluation of personnel are equally problems of evaluation of patient care. This is indeed a major study.

The Committee hopes that these articles will prove helpful in stimulating staffs to work out, in their own settings, programs of personnel evaluation that will lead to better patient care and greater employee satisfaction.

MARY L. RICHMOND, M.A.

Will cutting down or changing the kinds of fat we eat lessen the risk of a heart attack or stroke?

According to a new leaflet published by the American Heart Association some dietary changes have been recommended for people prone to these conditions. The two principal changes are: Eat less fat; substitute a substantial amount of liquid vegetable oils for

the solid animal fats such as butter and the fat in meat.

The leaflet includes definitions of the three main kinds of food fats and examples are listed in table form. Copies of "What We Know About Diet and Heart Disease" are available free of charge from the American Heart Association, 44 East 23rd Street, New York, 10.

Evaluation of Nursing Service Personnel

JEAN G. CHURCH, M.A.

Some pointers on the process of staff evaluation and report writing are discussed.

THE EVALUATION of the performance of nursing service personnel is one of the most important and difficult tasks of those who are responsible for the nursing care of the patient. A systematic, periodic evaluation of the work of every person on the unit is necessary for a high quality of nursing care as well as for the guidance and development of the individual worker. The purposes of evaluation are:

1. To help the worker to develop an attitude toward her work that will enable her to see her contribution in relation to the total work of the unit, with the result that she will give better nursing care and become, herself, a more satisfied worker.

2. To provide a basis for regular individual conferences between the worker and the head nurse or supervisor, for the purpose of reviewing her performance and assisting her in arriving at and maintaining her best performance.

3. To provide records that will be of value in making promotions, transfers or dismissals; making salary adjustments; giving a fair estimate of the quality and type of work when references are sought.

In simplest terms, a good program of staff evaluation will result in better nursing care for the patients and a more satisfied group of workers. To achieve this, evaluation must be a continuous process — not just something that is done at the end of the month or the day before the nurse leaves the unit. Sometimes evaluation is thought of in the narrow sense of "telling the nurse how she is getting along." A good program of evaluation goes far beyond this because it helps the nurse to see clearly her part in the nursing service team; gives her recognition and commendation when due, and guidance and encouragement when necessary. Evaluation is a step in bringing about, as well as determining, progress.

The head nurse is constantly rating or evaluating her staff. This is something that she does every day,

whether she is aware of it or not. By virtue of her position as "head" nurse, she is responsible for the performance of those who are nursing on her unit and she is concerned about the quality of this performance. She knows what constitutes high quality nursing care; acceptable versus unsatisfactory nursing care. It is interesting to note that the head nurse who sets high standards of performance is likely to elicit this kind of work from others. Since most people live up to what is expected of them, a high level of expectation helps to maintain a high quality of care.

In all walks of life, evaluation of individuals and groups of persons is continual. "This person is better looking than that one; shows more initiative; is more charming." "This student is better in the classroom than on the wards." We hear these kinds of statements every day. Some have valid bases while others are quite superficial and have little foundation in fact. Whatever the bases, everyone evaluates. This process of appraising, or putting a value on, is very prominent in our everyday life. Nearly everything we buy bears some stamp of approval: eggs, butter, yard goods, gasoline, and so on. This kind of appraising is not too difficult because we are dealing with inanimate objects where it is possible to measure for exactness, test for performance, inspect for flaws. In other words, does the article come up to standard? There must be some standard for a Grade A egg!

It is another thing when we try to assess or evaluate a person — the nurse. For one thing, we do not have a list of standards against which to measure the competency of the new graduate, the experienced graduate, the nursing student, the nursing assistant, and others. For the worker in a candy factory, the standard of efficiency might be the number of chocolates packed in a box in the course of a day. The more boxes packed, the more efficient the worker.

Unfortunately, there is no such simple method of measurement in nursing. Nursing involves highly complex skills and human relationships. What the nurse *is*, as well as what she *does* is important. The way she does what she does may be as important as the results achieved.

Evaluation of nursing personnel is a difficult task, and it involves two problems: (1) *What* is to be evaluated? (2) *How* is it to be evaluated?

What Is To Be Evaluated?

In any undertaking, it is necessary to have a goal in mind. Without a definite goal it is impossible to know where you are going. Before the head nurse can evaluate her staff she must know the characteristics and abilities which she expects them to possess. Then she must be able to determine the extent to which these qualities have been attained. These characteristics and abilities are often listed on the evaluation form under such headings as: general nursing ability, cooperation, loyalty, leadership, personal appearance, and so on.

As well as knowing the professional and personal qualities to be evaluated, the head nurse must be familiar with the job that is expected of each worker on the unit. Then she can ask herself "Is the worker performing the job she was hired to do? What standards of performance have been established? Does the performance meet them?"

Using Her Powers Of Observation

The best technique for evaluating performance is observation. The evaluation report is based on observation of the nurse at work — that is, observation of her skills and her behavior. With this technique the head nurse is evaluating what the nurse actually does in the working situation — her everyday, typical behavior. The observations are ultimately recorded on the evaluation form. This means that the basis of a good evaluation report is good observation. Here is an example of good observation of the nurse at the bedside. This is taken from *The Hospital Head Nurse*, Wayland *et al*, 2nd edition, pp. 474-475. While it refers specifically to the student nurse the situation could apply to any of the nursing personnel:

In observing the care given by a student to a child needing a sterile ear irrigation following surgery, the head nurse has an opportunity to appraise the student's attitude toward the patient, her ability to win the cooperation of the child in her treatment, her mastery of the procedure, and her ability to make the adjustments necessary because the patient is a small child. Also, and simultaneously, the head nurse can observe the suitability of the student's appearance, the neatness of her uniform and the like, but should appraise each different ability separately and should beware of being influenced in the evaluation of the student's ability by outside factors that have little bearing on what is being measured. The student's understanding of the difference in the direction of the angle of the child's ear canal from the adult's — an understanding that causes her to adjust and hold the irrigating nozzle at a different angle than that for an adult — should be evaluated separately from her habits of grooming. Accurate knowledge of principles will not compensate for poor practice in asepsis, nor will a pleasing manner; each should be appraised separately.

The head nurse has many opportunities to observe the nurse. Her best field of observation is at the bedside of the patient. She also sees the nurse and observes her behavior in the workrooms as she prepares for treatments and cares for equipment. She observes her as she does her charting and gives reports. The head nurse notes the kinds of questions the nurse asks, the thoroughness of her reports, the comments she makes about patients, her co-workers and her assignments. Her relationships with doctors, visitors, other nurses and non-professional workers are noted.

It is one thing to observe the nurse — but what do we do about the observations, or do we have to do anything about them? Why can't we summarize in our own minds these day-to-day observations and when the time comes fill in the report? The answer lies in the frailty of human memory. We make many observations of other people — so many that they all melt together in our memory and only a rare few of the most striking retain their individuality. Even these become warped and distorted with the

lapse of time. It is therefore essential to record the observations promptly, while the situation is still fresh in our minds.

This is the second step in evaluating — to record the observations. One of the best aids is the anecdotal record. An anecdote is a brief account of an incident and on the ward significant incidents which show personality traits, the presence or absence of skill or understanding, the quality of work, are written down when they occur. If the anecdotes are accurate, well selected, and clearly written the head nurse has a record that gives her a picture of the nurse and her work. This in turn serves as a sound basis for preparing the evaluation report. This type of recording can become cumbersome and time-consuming, and therefore it must be kept simple. As the head nurse observes her staff, she must decide what items are worth recording. She keeps in mind the particular qualities and characteristics which she expects the nurse to possess or develop, and seeks evidence of these traits in the nurse's day-by-day behavior. If the hospital has its own evaluation form the head nurse should become thoroughly familiar with the items on which she is to assess the nurse, and then actually look for evidence of the presence or absence of those qualities. For example, if the nurse is to be rated on "tactfulness" she should watch for examples of this quality.

It is important to be careful to record the favorable as well as the unfavorable incidents. It is very easy to emphasize the undesirable items of behavior that were observed and that need to be corrected. There must be many favorable, desirable nursing qualities as well, else why is that nurse on the staff?

On the basis of the anecdotes that she has collected the head nurse judges whether the nurse is thoughtful, considerate, cooperative, skillful; whether she shows organizing ability, leadership; whether she has made marked or little progress.

Preparing the Report

After observing the nurse and recording the observations, the next step is the preparation of the evaluation report. This is not easy to do. There

are many problems and difficulties that may arise. It is interesting to note that these problems are not peculiar to nursing, they are the same in industry, civil service, the armed forces and other similar groups where salary and promotion often depend on the rating the individual gets. Some of the problems are:

1. *Ambiguity of the terms used:*

Many forms use broad, abstract terms that vary in meaning from one person to another. What is meant by initiative? The kind of behavior that indicates initiative to one person, may be regarded as insubordination by another. Dependability? Does this mean coming on duty ten minutes early every day? The rating that is given depends on what the term means to the individual doing the rating. To do a proper job, the head nurse must know what is meant by the key words.

The categories such as average, above average, etc., are not always clearly understood. What is average? In rating the student nurse, what is average for the junior? the senior?

These terms must be clearly defined so that the meanings are clear to all. This could well be a project for staff conferences. One of the best methods is to develop concrete examples of the various traits and behaviors, and discuss their meanings. For example, "this nurse did such-and-such under these circumstances. For a nurse at that level, this signifies a fair amount of 'resourcefulness.'"

2. *Personal prejudices:*

It is well for the head nurse to remember that we all have biases and prejudices that we carry around with us. We don't like blondes; we believe that young nurses are careless; older nurses are bored; etc. These prejudices help to form our impressions of persons. They color our reactions to them and enter into our evaluation. Incidentally, not all these prejudices are on the negative side. We may have an equally strong liking for a person or particular type of person. Again, the rating may be distorted.

3. *Halo effect:*

This is the tendency to rate a person in terms of an over-all impression. A person is good in one area and therefore must be good in another; poor in one area and therefore poor in everything! When the halo effect operates, we allow a favorable or unfavorable impression concerning one aspect of an individual to

color all our observations and thinking about that person. This is the careless kind of generalizing that is frequently seen in the hospital situation. For example, a young nurse does one unfortunate thing and that is held against her no matter how skillful she may be or how much she may have learned from the unfortunate experience. In the quotation from *The Hospital Head Nurse*, it was noted that a pleasing manner has nothing to do with aseptic technique! The head nurse must guard against this halo effect, and as she evaluates she must be careful to rate each quality and ability separately.

4. Generosity effect:

This is the tendency to rate a person higher than she deserves. There seems to be an unwillingness to condemn with the result that there is a tendency to rate a person at the higher end of the scale. Or, if the nurse is not doing as well as she should, just "give her average."

5. Too big a job:

In the attempt to get away from a superficial report, the form used can become very cumbersome and unwieldy with too many items and categories. One of the most widely used books on ward management gives an example of an evaluation record for the graduate nurse. This record lists approximately 40 abilities and qualities on which the nurse is to be rated. This means that the person who prepares the report must make 40 separate judgments about the nurse! If she has five reports to do, she has 200 separate judgments to make! There is a danger here that the evaluation form itself can become too time-consuming and too thought-consuming, so that inevitably the task is done with an eye toward getting it over with rather than doing a good job.

These are a few of the pitfalls that create difficulties for the person who has the responsibility of evaluating the nursing personnel. Unfortunately, there is no magic formula — no shortcut that will ensure success.

Discussing the Report

When the report is completed, the job of evaluation is only half done. Evaluation is based on the principle of self-correction. The report must be discussed with the nurse. She is expected to use the results in a process of self-improvement. This emphasizes

the fact that the nurse being evaluated has the right to expect to be evaluated with care by competent observers who know what they are doing.

Most nurses do not like doing evaluation reports. They like even less discussing the report with the person being evaluated. However, it should be kept in mind that the main purpose of the report is to help the nurse to improve — she has the right to know her strengths and her weaknesses and she needs guidance and direction. There is no problem in discussing the report with the nurse, if the report happens to be good, but most of us hesitate to point out weaknesses.

Perhaps we could improve this negative attitude by taking a look at the world of sport. The head nurse or supervisor should think of herself as the "coach" or "trainer" whose main concern is that the members of her team will do the best they possibly can. The coach is trying to bring out the best in his protégées, and to do this he must correct defects in their performance. This is the sort of thing that is seen in the TV fights — between rounds the boxer gets pointers and directions from his "coach." He is told how to do a better job. The person responsible for the performance of the boxer has been keeping an eye on him, seeing areas where he could improve. In a sense he has been evaluating the performance.

The head nurse or supervisor has a responsibility to bring out the best in those who are working on her unit. If she could look upon herself as a kind of "coach," perhaps she could see that it is part of her job to try to bring out the best in her staff. Then she would not be so hesitant about pointing out areas of weakness. Furthermore, she should use every opportunity to encourage the nurses to evaluate their own work.

If evaluation does not result in better performance on the part of the individual worker, it is not achieving its maximum effectiveness. Better performance by the workers means better nursing care for the patients. The end result is that the morale of the staff is high. The head nurse who puts forth a real effort to institute and maintain a sound program of evaluation is amply rewarded.

Performance Evaluation in Nursing Service

JOAN M. GILCHRIST, B.N.

Nursing service administration is concerned primarily with quality nursing in the quantity demanded by the situation. Evaluation is one of the tools or activities through which this is accomplished.

RECENT TRENDS in performance evaluation lean strongly towards counselling of the individual in matters of morale, adaptation to the work situation and self-improvement. Without minimizing this particular purpose of an in-service educational program this tendency, were it to go too far, might well result in the welfare of the nurse taking precedence over the welfare of the patient.¹ It is not the nursing personnel who are being evaluated but rather their performance, the objective being to provide excellence in patient care. Such an evaluation also serves as a basis for promotion, disciplinary measures, and records through which more valid references may be given.

Once we have conceded the importance of evaluation as one of the means by which our administrative function can be served, we then must decide the method through which it can be attained. With regard to the implementation of a system of evaluation, Finer states:

For ease in the establishment of ratings, many kinds of forms have been invented, all with some degree of merit. An indispensable ingredient of any such forms is a list, corresponding to the nature of the job, of the elements of the performance or productivity of personnel.

At first sight, almost anybody could use such a form, merely matching the descriptions of the qualities listed and to be rated with the performance under supervision. Yet, for at least a quarter of a century, rating experts, whether in business, school, industry, or government, have been convulsed with anxieties. Why? Because their descriptions leave so many matters in doubt. For example: is the item chosen for judgment of importance on the job? How important is it? Is it described so as to defeat favor-

itism or "subjectivity" of assessment? Does the verbal description lend itself to a numerical or adjectival grading?

In nursing service, head nurses and supervisors have often been faced with the task of utilizing one of these forms. How often are they entirely satisfied when they complete one that objectively evaluates an individual's degree of "neatness," "punctuality," "cooperativeness," "initiative," "organization" and so on? How often do they reach conclusions regarding the degree of merit relative to one of these terms on the basis of one or two specific incidents, usually good or bad? Of what importance are these qualities in, and of, themselves in promoting excellence in patient care? Could it not be true that an individual who received a low rating in a number of these areas might still be a fairly adequate and capable nurse? Has anyone noticed if the use of a rating form has improved patient care? It seems that abilities and/or degrees of performance are not readily measurable in these or other commonly used terms. True, there is a degree of merit in most forms, yet the traditional checklist serves to divide nursing and the nurse into ambiguous and obscure parts. This pattern emphasizes *praise* or *blame* of the individual rather than the progress which the nurse is achieving in meeting the needs of patients. There is no standard evaluation form that can achieve the desired results. Indeed, we can safely "assume that the perfect rating form has not yet been devised."² If, however, we concede the importance of evaluation, then how can we work towards better methods?

For a system of evaluation to merit the time spent on it, it seems important to begin by establishing the desired goals of performance and then to

evaluate the performance in terms of achievement of these goals. Rather than trying to evaluate isolated bits and pieces of nursing care and personal attributes, it may be more advantageous to look for the individual's *pattern of nursing*. Perhaps by a careful scrutiny of this pattern we can better achieve the purposes of evaluation.

Let us suppose that a director of nursing, or one of her staff members, has decided that there is need for a systematic procedure of evaluation. The ultimate responsibility for meeting this need belongs to the director of nursing but she may choose to delegate to one of her staff members the task of setting the wheels in motion. Regardless of who directs the project, if it is to be understood and used effectively, all staff must participate in developing the method of evaluation. Reading about evaluation, a willingness to experiment, and group discussions are necessary elements of the process. Throughout the formulative stages, two factors must be kept in mind: the desired goals of the nursing service, and a clear identification of the components of nursing necessary to achieve these goals. Before any performance evaluation guide can be formulated, the staff must clarify their thinking with regard to these factors. It is hoped that this results in a form which is specifically oriented around the needs of the institution that it serves.

Where does a group begin in organizing an evaluation procedure? Is there, perhaps, a basic pattern that can be adapted to the philosophy of care given in the institution? Can we identify universal components of nursing and the nursing method? If the answers to these questions are in the affirmative, the form could ultimately consist of a series of questions related to each of the accepted components of nursing and the nursing method. Moreover, if we accept the premise that performance evaluation is concerned with how an individual functions in particular situations, the answers to these questions would require a description of behavior relevant to the particular component. What are these universal components of nursing and the nursing method? Although they may be

stated in a number of ways, perhaps it is possible to identify them as follows:

1. *Assessment of the nursing requirements*: Before any nursing can take place, the practitioner performs some kind of assessment of the needs of the individual being nursed. This assessment is made in a variety of ways and each group may suggest questions of a slightly different nature, the answers to which will indicate the evaluatee's performance in this area. For example, one question in this section may be "What source material does the nurse consult in assessing the individual needs of the patient?" The answers to this question could include a description of the nurse's observations of the behavior of the patient and his physical condition, discussions with the family regarding the patient and the family situation, consultations with other professional workers, and reference to charts, texts and other sources.

A second question might be "How does the nurse utilize the material so gained in identifying the important factors and essential needs in the situation?" Here one may indicate how the nurse uses her observations and information gathered from various sources to determine the needs of this particular patient and in setting the goals for nursing.

2. *Planning the nursing care*: Once the nurse has completed her initial assessment, she will begin to plan the nursing care. Although this is not always a written plan, it is usual to have at least a kardex or similar guide and, of course, the unwritten thoughts and ideas of the nurse as she mentally calculates and evaluates the situation. These latter may not be evident until one observes the nurse carrying out her plan, but a question in the general area of planning might be "How does the nurse use the information gained during her assessment to plan for the nursing care of each individual?" One might note whether or not she uses it at all in evolving an individual plan and if so, to what extent. Does she, for example, note that he needs rest and so plan to give him as much of his care as possible at one time? How does she provide an environment which is conducive to rest? It might also be asked in the general area of planning "How does the nurse take into consideration the continuity of,

and development of nursing care for long range as well as immediate needs?" One might observe that a nursing care plan is made so that other nurses could use this information in planning their care, or that a comprehensive verbal report was given, or that succinct and complete information is charted or perhaps all of these are done. Does the nurse plan for the rehabilitative needs of the patient and begin these shortly after admission? Are these reviewed and amended daily throughout the patient's stay in hospital? Do they include sufficient opportunity for the patient to learn to meet these needs following discharge?

3. *Carrying out the plan of care:*

When the needs of the patient have been assessed and a plan of care developed, the next logical step is to carry it out. Nursing functions in the promotion of health and goes on during the various phases of illness, for example: in the areas of therapy, rehabilitation and prevention. It comprises aspects that are therapeutic, supportive and of a teaching nature, and includes methods that are technical, manual and interpersonal. These are the components of nursing which need to be described.

It is likely that the nurse's first consideration would be to make the patient as receptive as possible to the care she has planned. It might be asked then "How does the nurse prepare the individual and his family, and gain their cooperation in administering the plan of care?" Does the nurse describe her basic plan to the patient in terms understood by himself and his family? In what other ways does she proceed to enlist their support and assistance? Does she, in essence, involve them in the plan?

In stressing individuality of patient care, there is concern that nursing be patient-centred rather than procedure-centred. Perhaps this area should include a statement such as "Indicate the ways in which the nurse shows cognizance of the need for modification of procedures to adapt to the response and comfort of the patient, and her skill in the performance of therapeutic and supportive techniques." Observations might include any number of ways in which the nurse changed a routine procedure to make the patient more comfortable, to make him more receptive, to facilitate the maximum effect, and so on. One can note how deftly she performs the procedure, if

principles of asepsis are carried out, if the procedure is performed at an appropriate time in accordance with medical orders and other needs, and if the patient-nurse conversation during the care is helpful to the patient and the nurse.

"How does the nurse deal with emergency and stressful situations?" Does she perform very ably in clear-cut routine circumstances, but find it difficult to make a rapid decision, or act appropriately without a great deal of thought? What is this person's behavior pattern when a difficult situation arises? Is she able to consider all the facts, and weigh them according to their relative merits in making a decision? Or does she avoid decision-making when possible? Regardless of the specific goals outlined by the staff, these answers would illuminate the behavior pattern of the nurse in emergency situations.

Interpersonal relations are of primary importance in nursing. Pertinent questions might be "How does the nurse show an understanding of her own needs, feeling and motives, and a knowledge of ways of coping with them in fostering interpersonal relationships with others?" "In what ways does she try to promote a therapeutic relationship with the patient?" The observer might note that the nurse has a quick temper, for example, but that she seems to be aware of this and makes certain efforts to control it. The relationship between the nurse and her patient might be observed as one which does or does not promote mutual confidence and respect.

4. *Evaluating the plan of care:* As nursing care is progressing, it must be evaluated in terms of its effectiveness in meeting the needs of the patient. How does the nurse use her observations of the response of the patient to therapeutic measures and supportive techniques in evaluating the effectiveness of her nursing care plan? She may note, for example, that the patient does not understand his part in the nursing care plan, that he is not comfortable after certain procedures, or that he is not achieving the desired amount of rest. On the other hand, he may have confidence in her ability to give him good care and may be very willing to pursue new angles with her in developing more profitable methods and techniques. It is only through evaluative measures that care can be established which will overcome

the evident defects in the plan.

Are there problems inherent in the situation with which the nurse realizes she is unable to cope? "How does the nurse indicate an awareness of her need for professional growth and development?" "How does she show responsibility for self-direction in further learning?" might be asked. Does the nurse feel confident in approaching others for help where needed or does she merely accept this lack and do nothing about it? Is there evidence of interest in those needs of the patient which she has not met and willingness to seek out information and apply it to the situation?

Summary

The universal components of the nursing method have been identified as: assessing the nursing requirements, planning the nursing care, carrying out the plan of care and evaluating the plan of care.

In order that descriptions be provided in these four areas very keen observation is required which must be continuous and cumulative, and the answers limited to those areas which have actually been observed. The particular questions formulated will no doubt vary from one staff to another, and supply the individuality previously noted. The key to the use of this type of form lies in the ability of the evaluator to describe accurately the behavior that she has witnessed without subjecting it to personal judgment.

True and complete objectivity is impossible to attain. Social psychologists have shown that we tend to select for comment, on a personal basis, those things which to each of us seem most enlightening. We perceive particulars according to our own frame of reference which draws heavily upon past experience.⁴ In order that this be as objective as possible, however, the structure must exist in which evaluation through observation of be-

havior can take place. The evaluator could perhaps set aside a particular time for such observations and merely record the behavior of the individual being evaluated at this time. This precludes the possibility of only "good" or "bad" incidents being recorded. Rather, any behavior that happens to be occurring will be noted. This supplies the *pattern of nursing* being carried out by the individual. One can observe any change in this pattern over a period of time. Evaluation takes place when the pattern of behavior that is observed is related to the achievement of the overall objectives of the nursing service.

It can be noted that personal characteristics have not been included. The writer feels that these are only of importance to the degree that they affect the ability of the person to nurse. When they do affect this ability, this becomes evident through the behavior of the individual in one or more aspects of her nursing evaluation.

An attempt has been made here to provide, through the use of the general components of nursing and the nursing method, a guide that can be utilized in many situations. By its very nature, the use of such a form will demand that all personnel accept this broad and comprehensive approach to patient care and its logical components. It is felt that this kind of program is basic, not only to evaluation methods and procedures, but to producing the best possible quality of nursing care.

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A research study carried out in Michigan shows that one out of six hospital patients stays too long or leaves too soon, in terms of definitions developed by teams of physicians for various disease classifications.

Flagrant cases of over-utilization are not the problem; but the large number of one

or two-day overstay represents a threat to adequate and economical health care.

Patients 65 years of age and older use the hospital most; have the greatest need for its service, and have the least prepayment and insurance protection.

The Modern Hospital

A Head Nurse's Ideas on Evaluation

FREDA WOODWORTH

Evaluation is a guide to the level of growth and development.

SUCCESSFUL evaluation paves the way to improvement in nursing care. Head nurses everywhere are concerned with both of these facts in their daily work. We must understand the purpose evaluation serves; be aware of some of the problems involved in evaluating graduate nurses, and conscious of the techniques and methods of approach that are essential in the formulation and presentation of a report. I will suggest some ideas on how present methods might be improved.

In making an appraisal at the graduate nurse level we are not usually testing their factual knowledge. We concentrate on observing such abstract qualities as understanding, attitude, appreciation, and more generally resourcefulness, dependability, cooperation, initiative. These subtle characteristics can be measured only by observing behavior patterns. Sufficient samplings allow us to form a basis for judgment. These higher levels of achievement are much more difficult to assess than simple skills.

The degree to which staff nurses possess these attributes is important. It is necessary to keep continuous files on each person. This information is useful for purposes of promotion, recommendation, dismissal.

Evaluation plays an important role in the professional growth of the individual nurse. It provides a guide by which she can measure her progress. It leads her to self-analysis since it is based on the observations of another individual. She can be guided to reflect on her position with relation to present hopes and future goals. As she receives successive reports she can follow her growth.

A nurse can recognize and then identify her own areas of weakness and still maintain her dignity. This would seem the more ideal method of evaluation.

When a head nurse is testing achievement she must be aware that

there are objectives to meet, standards to maintain, attitudes to be appraised and qualities to be measured. In composing a report she is bringing into conscious awareness the fact that desirable traits must be identified and developed; that undesirable ones must be recognized and discussed. She focuses on ideals which practical routines tend to destroy.

A basic understanding of the principles of the evaluation process is essential. Even though she has this knowledge, the head nurse still faces a complicated problem. She has a very real responsibility to her administrative department, to those she is evaluating, and to herself. It requires courage, integrity, and the ability to discern.

Evaluation is generally associated with the words "judgment" and "criticism." Appraising, in this sense, has an unpleasant connotation. Most of us have had associations with it since early childhood.

The most valuable tool for constructing a written report is the anecdotal record. The graduate nurse demonstrates, in the light of certain situations, qualities from which the head nurse infers that she is responsible and/or dependable.

It goes against our natural inclination to assess other people in a serious *written* report. No matter how excellent a report may be, no matter what pains are taken to produce a tactful and sympathetic delivery, the report is generally accepted as a judgment rather than as guidance to learning.

Time is a factor of major concern to the head nurse in producing a satisfactory evaluation of merit. Behavior patterns must be observed. Anecdotal records must be kept, not on just one but on every member of the staff. When an evaluation form has been completed, time is needed to present and interpret it to the recipient. The head nurse worries most about two groups of nurses: The nurse who needs a great deal of guidance, and

the one who simply cannot be helped through any amount of leadership. These are the nurses who need to be counselled with care so that they can identify their own needs. One cannot be discerning in a hurry. As a result, we often fall short of our objectives. There is not time during the hospital day to do justice to such a task, and the head nurse is reluctant to require the graduates to use their off-duty time for this purpose.

It would be interesting to know the amount of time in hours that goes into the writing of a single report. One report in no way simplifies the preparation of another. Each must be carefully thought out and composed. Thought and consideration must be woven into its warp if it is to command the respect and acceptance of the receiver. If a nurse is in need of guidance, a full assessment of her work can rarely be written at one time. To be certain of maintaining reliability, objectivity and validity, the head nurse often feels she must think over the evaluation in different moods and on several occasions.

The degree of maturity of the nurse who receives the report largely determines its value. No matter how gently suggestions are put forward, there are those who will instantly translate them into a critical analysis. The maturity of the head nurse is also important. The ability to erase her personal bias from the reports she prepares is a hard thing to develop and control, though the necessity to do so is easily recognized. She is also faced with the problem of finding a working area where she can have peace and quiet, with few interruptions. Suitable places for the preparation of reports are sadly lacking in most hospitals.

The staff nurse is not without her problems with regard to evaluation. Often, she does not understand exactly what is expected of her. On many wards, objectives are not clearly stated or understood, and she is often frustrated by lack of concrete goals with which to identify her own.

Most general staff nurses have a meagre understanding of the meaning, the purpose, and the value of an achievement report. They are seldom sympathetic toward this procedure. In particular, new graduates are inclined

to feel that such reports are a milestone they passed when they completed their student program. Even though the objectives of the report may be clearly stated on the form, the preconceived ideas of the nurses color their interpretation of its purpose. They usually appreciate guidance on an informal level but they do not understand the formal procedure.

Staff nurses have heavy working responsibilities. Their days are filled with interruptions and frustrations. Pressure is constant and organization is hard to maintain. They view evaluation as just an extra burden.

In addition to the written report, there are various techniques that may be employed in the evaluation of nurses. Well deserved praise and expressed appreciation for a difficult job that is done well always stimulate greater effort. The head nurse often discusses situations (both desirable and problematic) in a casual manner at the time they arise, and the outcomes are positive. She may decide to elaborate on a subject with a group of nurses, hoping that certain members of the staff will identify themselves with the matter under discussion and thereby benefit. Nothing on a written report should ever come as a surprise.

The example that the head nurse sets serves as a stimulus to the nursing staff. They are influenced by the standards of care which is maintained in an area. They have an opportunity to know and understand the head nurse because they work in close association with her for long periods. They identify themselves with the department and take pride in maintaining or elevating the standards of care. If they respect their head nurse they are able to appreciate her suggestions and her help. Working with her toward a common objective is very satisfying and sets a firm foundation for growth and development for all concerned.

It is human nature to respond to that which is expected. The head nurse must expect good nursing care to be given and she must give her graduate an opportunity to prove herself to be responsible and dependable. She must know how to delegate responsibility to the nurses on her staff.

I have considered the purpose evalu-

ation serves. It should be of value to the head nurse as well as to the graduate and to the administrative body. The ideas that I would offer toward improving evaluation are not new.

One problem centres around the use of the words "judgment," and "evaluation." These words have different connotations. Achievement and guidance are more positive words, suggestive of growth and development; there is a generosity about them. We all know that we need help, but we also feel we can do without too much criticism. I believe that the word "evaluation" should be replaced.

We shall have to wait for a reconstruction of the whole educational

pattern of our profession before we can effectively solve this problem. The education of nurses to the principles of evaluation during their professional training is necessary. They are active participants in such a program. They should have a clear understanding of its meaning, purpose, and value. In-service opportunities for the graduates and the head nurses to discuss this subject would be rewarding.

Nurses in general must discard the thought of evaluation as a tool for critical analysis. We must recognize it as a guide to growth and development. By stressing the importance of the latter we will be better prepared to offer superior nursing care.

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It is characteristic of the human mind to hate the man one has injured.—TACITUS

SO YOU NEED A CONSULTANT

JEAN HAYTER, ED.D.

Adequate preparation is required before a consultant is called in to help.

WHEN A PROBLEM arises, the suggestion is often made that a consultant be called to help solve it. It is sometimes assumed that the consultant will take care of everything and that the problem will inevitably be resolved. If this proves not to be true, the consultant frequently is criticized, although he may have done all he could under the circumstances. However, it may be that a consultant is not needed for the successful solution of the problem or that circumstances are such that a consultant could not help. Also, it often is not realized that the consultees determine to a great extent the success or failure of consultation. I should like to explore some of the factors the consultees can consider in deciding whether to call a consultant and some ways they can increase the likelihood of a successful consultation.

The consultees can *define the objectives* they wish to accomplish. When they have clarified what they wish to do, places where they are failing to meet their objectives may come to light. Then, it will be easier to determine why this failure is occurring and what can be done about it.

The consultees can *attempt to formulate the problem*. The difficulty may exist as a clearly defined problem. However, more commonly the consultees recognize the need for help merely because of feelings of uneasiness or dissatisfaction but are unable to identify the real problem. Prior to calling a consultant, the consultees can discuss the problem, subject it to critical appraisal, and refine their description of it. They can explore the steps leading up to recognition of the difficulty and obtain all the information available concerning it. By analyzing the situation in this manner, it may be possible for the problem to be pinpointed and some of the reasons for the underlying difficulty discovered. When this is accomplished, the solution may become apparent.

Each situation imposes certain limit-

ations and these can be identified by the consultees. They can define boundaries imposed by cost, time, equipment, personnel, or other factors, so that the framework within which they must work is understood and the limitations recognized. It may be that when these limitations are delineated it will become apparent that a consultant could not help in correcting the difficulties. If factors over which neither consultant nor consultees have control go unrecognized, feelings of inadequacy, anxiety, or hostility may develop. In any event, if the consultees are aware of the limitations within which they must work, they can take a more realistic viewpoint toward the things they may do and those they may not do. They can avoid being impractical and can make plans that it is possible to accomplish in their situation.

The consultant is to be viewed as *an aid to problem solving, not a substitute for it*. He is to be considered as a resource person, one who possesses sufficient knowledge and experience to give assistance or counsel in the area of his specialty. Just as sound educational measures engage the learner's participation, active participation by consultees in the process of consultation is desirable. Towle says, "It is important to meet valid dependency freely, without taking the management of the situation out of the learner's hands." Therefore, the consultees should accept the consultant's function as that of helping them learn to solve their own problems. They should constantly move toward greater independence.

The consultees can be realistically *informed concerning the kind of help they can expect* from a consultant. Even though they suspect that a person with special knowledge and skill could help, they may not be able to state specifically what they wish him to do. If the consultees do not know why the consultant is being invited, they will be unable to tell him why

he is needed. Furthermore, they are not likely to get the help they need due to this lack of understanding. The consultees can attempt to identify the area or areas within the problem for which additional knowledge and skill are needed from an outside source. If possible, they should attempt to determine the areas of need which should be given priority. If this plan is followed, the consultees will be able to state specifically the help they desire from an outside expert.

The consultant can be of more help if he is *invited at the appropriate time*. A consultant is not needed every time there is a problem to solve, nor should the other extreme hold — that the consultant be called only as a last resort to keep the group from utter frustration and disintegration. The optimum time to call a consultant is somewhere between these — when the consultees have assessed their needs and have decided that they can go no further without the help of an outside person without wasting time.² Although a crisis creates points of anxiety in which intervention may be helpful, consultant contacts are best not limited to times of crisis. The use of a consultant at the appropriate time may very well help to avert a crisis.

The consultees can *secure the approval of all concerned*, including the administrative officials, before inviting a consultant. Failure to do this may prove embarrassing later and may seriously interfere with the effectiveness of the consultation process. Successful implementation of plans depends largely upon administrative approval. In addition to the fact that an uninformed or unreceptive administration may hamper the consultation process, it is to be remembered that administrative attitudes travel down the line and influence others. Even though the consultant is invited by someone in the consultee institution, the persons directly involved may not desire consultation. They may fear that the inviting of a consultant will represent acknowledgement of, or will lead to exposure of, their inadequacy.³ In such a case, they may perceive the consultant as a threat to them and there is likely to be resentment. In any situation in which the consultees feel threatened, the threat must be reduced

before consultant and consultees can work together effectively. All who are involved need to desire the services of a consultant and to see him as a potential source of help. The consultant is more likely to be perceived as a possible source of help in finding effective solutions to problems if all involved have given their approval for the consultant's visit.

Careful selection of the consultant can do much to insure that the desired help will be obtained. It is the responsibility of the consultees to select a consultant who is believed to have the abilities needed to help them with their problem. Obviously, this is easier done if the consultees have decided what help they need. The consultees should select a consultant who is considered by the group to have superior working knowledge of the subject or problem area. The choice should be based upon authority of knowledge and ability, not authority of position. The consultant is given an opportunity to accept or decline, depending upon whether he feels that he can give the kind of help needed. Also, the consultant is allowed to decide whether to accept if there is a difference in values of the consultant and consultees. The consultees can expect the consultant to shift his expectations and his role to conform to the needs of the consultees, so long as they are within his value structure. The consultant is not to change the situation to suit himself but is to accept the consultees as they are. However, he should not be encouraged to accept if he feels that external pressures may influence his role to an undesirable extent or if he feels that the expectations of the consultees are beyond his abilities. If there is agreement by the consultee group as to the consultant to select, it establishes a more receptive attitude and a better working relationship. Also, if the consultant knows his selection was based upon what he has to offer, and if he knows the group has confidence in him, he will be able to work more effectively.

Preparation for the consultant before his arrival, with attention to the responsibilities of the consultees, does much to insure success of the consultation. The consultees can make clear to the consultant that which is his part

in the whole, as they see it. The degree to which he is free to act can be made clear to all concerned, not only to enable the consultant to stay within the limitations of his position, but also to prevent members of the consultee group from asking him to go beyond these limitations. The consultees should not make unrealistic demands upon the consultant. He should not be expected to be an expert in all areas or to offer advice concerning problems outside his field of specialization. When the consultant has a clear idea of how the consultees view his role and why he is needed, he will be much more likely to be able to reach their expectations.

Plans for the time of the consultation can be worked out between the consultant and consultees. It is helpful if members of the consultee group can be free of other responsibilities at the time of the consultation. A time convenient to both should be arranged, if possible, so that undivided attention can be devoted to the problem under consideration.

The extent to which the consultant-consultee relationship is confidential can be decided prior to the consultation and can be made known to all participants. Both consultant and consultees will be more at ease if they know that all information will be held in confidence unless they are willing for it to be divulged.

The presence or absence of power or administrative authority, can be clarified prior to the consultation. In "pure" consultation, the consultant usually has no such authority. However, a status figure may have such authority in reality or the consultees may think of him as a person with administrative authority unless this is clarified. Persons who see their positions threatened by the possibility of what they may say or do in the presence of the consultant are not free to solve problems. The absence of authoritative pressure, and of the feeling that the person seeking help must accept the advice given, helps to establish the feeling that the consultation involves mutual effort on the part of consultant and consultees to solve the problem cooperatively.

It is very helpful for the consultees to assist the consultant in learn-

ing about the institution and the group with which he will work. The consultant will want to know something about the interrelatedness of the institution and the community, the philosophy of the institution, social climate, environmental and cultural aspects of the social setting, etc. The specific information desired by the consultant will, of course, vary according to the nature of the problem. However, supplying appropriate information regarding the institution and the consultee group will help to establish rapport and will promote an adequate working level of mutual trust and confidence, which is necessary for the effective give and take of the consultant-consultee relationship. It is to be kept in mind that the consultant is an outsider and is to be treated with the same deference as a guest.

Usually, it is desirable for the consultees to acquaint the consultant with the problem before the actual consultation visit, to enable him to think about it and to gather additional information concerning it. The amount and kind of information the consultant is to be given in advance will vary from one situation to another, however, and this can best be decided by the consultant and consultees cooperatively for each situation.

In many ways, the consultant and consultees are dependent upon each other. Consultation is a two-way relationship in which both give, both learn. The consultant and consultees must have respect for each other and both must view a successful performance as the creation of a relationship within which the consultees can increase their own need satisfaction and contribute more effectively to the achievement of their objectives. In the last analysis, the consultant-consultee relationship, like any human endeavor, will be only as effective as all the individuals involved make it.

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Motivating Employees to High Levels of Achievement

J. P. VILLENEUVE

A presentation to the operating room nurses' group of the Association of Nurses of the Province of Quebec in April 1961.

Introduction

ONE OF THE basic qualities that an efficient supervisor requires is an ability to motivate people to high levels of achievement. How can this be accomplished? A growing body of information has been accumulated, through painstaking research and observation in the social sciences, which specifically points the way towards the solution of "employee motivation" problems. From these findings there are nine simple ideas that can help the supervisor to make his people more productive. If the following principles are applied regularly, effectively and conscientiously both the supervisor and the employees will benefit in two ways:

1. The supervisor will be more valuable because departmental productivity will improve;
2. the employees will have the conviction that they "belong" and thus both their morale and their performance will improve.

Importance of the Human Element

The supervisor who always thinks and acts with good human relations in mind is likely to be far more effective than the one who does not. When employees are enthusiastic and cooperative, when they want to get the

work done, when they think highly of their jobs and their employer and are eager to help their co-workers, "human relations are good."

The importance of the human element in management cannot be overstressed.

Management is the development of people and not the direction of things. If this fact were more generally accepted many management difficulties would disappear. The supervisor who says that he would rather exhaust himself doing things correctly than expend the time and patience necessary to get other people to do them correctly is admitting that he cannot manage.*

The same attitude is expressed by statements such as "all managers are personnel managers" and "everything in management hinges around and involves the human element."

Some Fundamental Concepts

In order to view human relations in their proper perspective and to recognize their contribution to a successful organization it is necessary to understand certain fundamental concepts.

*L. A. Appley, Management the Simple Way, *Personnel magazine*, A.M.A. p. 598 (January 1943)

A consideration of human relations is not paternalism nor can it achieve universal happiness. It simply implies that the supervisor must understand human behavior and human motivation in order to provide the leadership necessary to achieve the goals of the organization. Nor is it the whole of management's job. Every supervisor must be concerned with costs, technology, and a host of other vital factors. It is, however, *one* of his essential responsibilities. Good salaries and stable employment, vital though they may be, are not sufficient to produce a contented, harmonious, and efficient team. Meeting material needs is never enough. An employee must feel that he is more than a cog in a machine; his desire for esteem and recognition must be satisfied. There is no conflict between this concept of human relations and the need to maintain the highest standards of work performance and make realistic, practical decisions.

The greatest single factor in the productivity of the individual is his attitude toward his supervisor. It is up to the latter to create the proper conditions *at work* for employees' development.

Nine Ways to Improve Employees' Productivity

1. Put them on the jobs they will do best
2. Keep them busy
3. Let them know how they are doing
4. Keep them informed
5. Ask for their ideas
6. Settle their problems promptly
7. Do not supervise them too closely
8. Understand them as a group
9. Develop their sense of responsibility.

Put them on the jobs they will do best

Most organizations take great care in the placement of employees. Proper placement is the key to good performance. An employee performs best when his job provides the widest scope for his abilities and the greatest opportunity for growth and superior performance. Where and how a man is placed often decides if he will be a productive employee, that is, if he will add to the economic and social strengths of the organization and find fulfilment in his work.

Selection and placement of personnel, as a systematic and continual effort, is one of the most important tasks of the supervisor. Selection is made at the time of hiring but placement is usually decided after the employee has had time to get to know and be known by the organization. Placement cannot be done once and for all. The efficient supervisor continually reviews placement decisions. Placing people in the right spot is an absolute prerequisite to high motivation and high performance.

Keep them busy

One of the basic ways to keep people happy and make them productive is to keep them busy. The average human being does not dislike work. Many gripes and complaints come from people who do not have enough to do. It is a psychological fact that most of us need to work to be happy. We need it to absorb our physical and mental energy and to make us feel needed, wanted and useful.

People not only feel better when they have enough to do they work better, too. The supervisor can keep his employees busy by planning.

1. Organize the department's work so that every person has enough to do.
2. Do not overstaff.
3. Keep on hand a stockpile of worthwhile projects that can be assigned on short notice during slack periods.

Giving an employee too little to do or accepting substandard performance deprives him of the solid sense of achievement which a good day's work brings.

Let them know how they are doing

Employees want to know exactly how well they are doing. They know when they have done a good day's work but they like to know that their supervisor recognizes the fact.

Monetary and mental wages

People work for two kinds of wages. One kind is the pay cheque; the other is the satisfaction gained from a sense of achievement and the sense of belonging to the organization.

If, over a long period of time, no one says a word to an employee about his performance, he will begin to feel that no one is interested. But if, from

time to time, someone says "Thanks for doing this job" or "That was a good job" or "It's good to see how interested you are in your work," the individual will feel that he belongs and that his efforts are appreciated. Monetary wages are very important, but, by themselves, they will never buy loyalty, cooperation or "plus production." Only mental wages can achieve these priceless qualities.

Keep them informed

The nature of communications between supervisor and subordinates probably has more impact on the employee's attitude toward the supervisor than any other single factor. To be positive, these communications should leave the employee with the feeling that his supervisor is genuinely interested in him — in his problems, his future and his well-being. If this feeling exists, the employee is likely to be a high producer. An employee is interested in what goes on in his company and wants his supervisor to keep him informed. He wants to know how it is doing because he knows that hard times could affect his job security. There are not many matters that are so ultra-secret that the supervisor cannot pass them on to the employees. Too many times people are kept in the dark needlessly to the detriment of good performance.

Ask for their ideas

Good communication downwards invariably results in good communication upwards. Keeping employees informed constitutes only *half* of the process of communications; the other half is giving the employees opportunities to express their ideas about the organization's or department's operations.

If supervisors want employees to feel they are part of the organization, they must solicit ideas and use the good ones. Employees not only help to solve problems but by *participating* they become identified with the goals of the organization which increases their motivation and efficiency. The channel for the flow of ideas is through the supervisor. He should encourage the people under him to think independently about the processes and methods used on their jobs

and about possible ways to improve them.

Interviews between an employee and his supervisor must permit a two-way flow of ideas. When the supervisor is giving an employee information regarding the plans and needs of the organization, the employee should feel free to suggest ideas concerning the work to be done.

It is also desirable to solicit employees' ideas through a formal suggestion system. Ideas collected through a suggestion plan save the organization a great deal of money. Perhaps even more important, employees who submit suggestions and see them put into effect get a real feeling of participation in the operation of the organization.

Settle their problems promptly

There is a direct relationship between an employee's productivity and his state of mind. No one can do a good job if he has things on his mind that irritate him. They may be imagined, unrealistic or untrue, but they are real to the individual. A problem, left unsettled, can grow into an issue of major importance. In an attempt to help we are all prone to give advice. We try to settle the other fellow's problem on the basis of what we would do, without realizing that he looks at it as an individual, too. Thus, the advice we give is sometimes impractical and therefore unacceptable.

Effective handling of personnel problems requires that the supervisor take prompt action in settling employee complaints, grievances or disputes. In settling these problems, the supervisor should first ask himself: "What's right?" rather than "Who's right?"

Do not supervise them too closely

In general, close supervision results in lower productivity than loose supervision. Close supervision indicates that the supervisor thinks getting out a certain volume of work is the prime reason for his existence. He may stress this idea to his group and give little freedom to the employees. Close supervision denies the employee all opportunity to use his ability to think, plan and organize.

It is a recognized fact in the field of human relations that employee pro-

ductivity is usually high when the employees enjoy some freedom in performing the work, can utilize their own ideas, judgment, and imagination and are left to their own devices. Maximum performance demands that an employee be left on his own as much as the circumstances of that job and his abilities permit.

Understand them as a group

Books on management and administration deal largely with the relationship between superiors and subordinates as individuals. Social scientists have discovered, however, that a superior's skill in supervising his subordinates *as a group* is very important to his success and his department's productivity.

High production groups show much greater group loyalty and group pride than low production groups. One reason is that the employees help one another in getting the work done. In the high loyalty groups, the employee feels that he is on his own and how he gets along with his work is his own responsibility.

How can group loyalty be developed? The supervisor attempts to establish a relationship whereby the group can perceive him as a *genuine source of help* rather than as a supervisor in the conventional sense. This will take time, but it is the long-term results which he considers important. This relationship fosters good team spirit with open communication. It permits the supervisor to understand problems as the employees see them and to interpret the employee's point of view to management. Every human being seeks a secure, friendly, and integrated relationship with the group that is most important to him; this group is almost always his work group.

Develop their sense of responsibility

Social changes have largely negated fear as a motivating force in our economic system. To perform well, a man has to assume responsibility for his actions and their impact. To perform better, he has to want to do better.

An employee will assume responsibility if he has supervisory vision, that is, if he feels responsible, through his own individual performance, for

the success and survival of the organization. This vision can only be attained through experience of participation. Pride and accomplishment do not occur apart from the job, they grow out of it.

Active and responsible participation of people in the improvement of their work and in the conduct of their own organization community affairs are probably the best means for employees to acquire supervisory experience. Included in these activities are the Social Clubs, the Employees' Welfare Funds, the Accident Prevention Programs, certain training courses, etc. Hospital-community activities need supervisory guidance but they should not be run by supervisors since they have only a minor impact on the hospital's success. These groups are important to the employee, if only, because they have a direct effect on his social life. By delegating the responsibility for them to the employees the organization takes advantage of its best opportunity to let them develop supervisory or managerial vision. Standards for these activities ought to be high because, more and more, they will become the means by which the employee will be motivated to superior performance.

The Employee

Each person that is supervised is an individual and different from all others. People differ in:

The relative strength of the goals they are trying to attain;

native endowment; some are calm, others insecure; some people learn quickly, others need a great deal of guidance;

physical make-up;

health;

social relationships;

financial status;

their past experiences;

the job they have to do. Some have jobs which are of tremendous interest to them; the job gives them a feeling of contributing something to the organization. Others have jobs which to them are routine, dull and boring; these individuals seek an expression of their individuality in other activities.

If we agree that the supervisor's main responsibility is to secure maximum productivity from each indivi-

dual, then we must understand each person. An employee should be considered as a long-term investment and it is up to supervision to help him make the most of himself. The maintenance and improvement of human resources is no less a supervisory responsibility than the maintenance and improvement of physical equipment. The social sciences are a rich source for supervisors in the achievement of their objectives.

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In Memoriam

Emily Amanda Ferguson, a graduate of Toronto General Hospital in 1923, died in Toronto on September 23, 1961.

* * *

Margaret Anne (Finley) Gardner, a 1924 graduate of Edmonton General Hospital, died on September 18, 1961. One of the first nurses to be employed by Indian Health Service, Mrs. Gardner was an assistant head nurse at the Charles Camsell Hospital, Edmonton, at the time of her death.

* * *

Lise Guillbault, who graduated from Verdun General Hospital in 1960, died recently.

* * *

Kathleen (Forshaw) Hallinen, a graduate of St. Paul's Hospital, Vancouver, in 1939, died on November 7, 1961 after a long illness.

* * *

Ruth Allison (Helmpel) Holton, a graduate of Royal Victoria Hospital Montreal, in 1946, died in Lindsay, Ontario, in November, 1961.

* * *

Jennie (Finley) Malcolm, a 1908 graduate from Saint John General Hospital and a charter member of the New Brunswick Association of Registered Nurses, died in Au-

gust, 1961 at the age of 75. During the Halifax disaster in 1917, Mrs. Malcolm was one of the nurses sent from New Brunswick to give assistance.

* * *

Marjorie (Harris) Homan, who graduated from Misericordia Hospital, Edmonton, in 1936, died on September 27, 1961.

* * *

Maud (Brown) Morgan, a graduate of Riverdale Hospital, Toronto in 1924, died in Sudbury, Ont. on November 4, 1961.

* * *

Margaret C. (Barrie) Nash, who graduated from St. Catharines General Hospital in 1937 died recently in Merriton, Ont.

* * *

Betsy (Beaton) Pattison, a 1930 graduate of St. Paul's Hospital, Saskatoon, died in that city on November 22, 1961. Mrs. Pattison had been employed at the Government Nursing Home, Melfort, Sask. prior to her last illness.

* * *

Wendy Cora Plumridge who came from Sydney, Australia where she had graduated in 1955, died in Toronto on April 30, 1961.

* * *

Aileen Marion (Benn) Pourbaix, a 1948

graduate of Edmonton General Hospital, died on November 23, 1961 following a brief illness. Until last June she had been on the staff of the Charles Camself Hospital in Edmonton.

* * *

Kathleen Mary (Hunks) Reinhart, a graduate of Homewood Sanatorium, Guelph, Ont. in 1939, died last year.

* * *

Anne L. (White) Rosser, who graduated from St. Joseph's Hospital, London, Ont., in 1929 died on May 12, 1961.

* * *

Marguerite Roy, who graduated from Hôtel Dieu, Montreal, in 1948 died at Princeville on October 1, 1961.



KATHERINE SCOTT

Katherine H. (Scott) Scott, a 1923 graduate of Toronto General Hospital, died in Ottawa on April 27, 1961 after a brief illness. Following completion of postgraduate work at the McGill School for Graduate Nurses, Mrs. Scott was on the staff of the Montreal Children's Hospital for a short time then returned to T.G.H. where she worked for 18 years as a member of the nursing school office staff. During World War II she served with the Canadian Orthopedic Unit in Scotland, returning to Ontario following the war to administer the D.V.A. hospital at Malton until it was merged with

Sunnybrook Hospital. Before her marriage to Rev. Stanley Scott, she was director of nursing education at Kingston General Hospital. Immediately prior to her death, she was associated with the Ottawa Civic Hospital.

* * *

Sister Mary Carmela (Lucy Fischer), a 1919 graduate of St. Michael's Hospital, Toronto died there in September, 1961.

* * *

Sister Irene Poisson, of Les Religieuses Hospitalières de St. Joseph, died at Hôtel-Dieu Saint Joseph d'Arthabaska, Que., on October 27, 1961.

* * *

Kate Esther (McDonald) Snodgrass, a graduate of the Municipal Hospital of High River, Alta., in 1923 died there on June 13, 1961 following a cerebral accident.

* * *

Doris Elizabeth Sobisch, who graduated in 1938 from St. Mary's Hospital, Kitchener died at Preston, Ont., on October 10, 1961.

* * *

Olive Marjorie (Keen) Thomas who graduated from Royal Alexandra Hospital, Edmonton, in 1932, died at Sidney, B.C. on November 12, 1961.

* * *

Margaret Wallace, who graduated from Winnipeg General Hospital in 1930, died last year. For the past 13 years she had been an instructor at the Baker Memorial Sanatorium in Calgary. Miss Wallace had served in several hospitals across Canada, including McKellar in Fort William, Archer Memorial in Lamont, Alta. and Royal Columbian in New Westminster.

* * *

Lottie (Fisher) Ward, a graduate of the Hospital for Sick Children, Toronto in 1927, died last year.

* * *

Marjorie Warren, a 1917 graduate of Royal Victoria Hospital, Montreal, died at Baintree, Mass., on September 24, 1961.

* * *

Mary Patricia (Hishon) Weiler who graduated from St. Joseph's Hospital, London in 1949, died at Kitchener, Ont., on May 18, 1961.

* * *

Jennie (Johnson) Windeler, who graduated from Vancouver General Hospital in 1915, has died.

Two men look out through the same bars: one sees the mud, and one the stars.

NURSING PROFILES



SALOMEA TRETIK

Salomea Tretiak has recently been made an assistant professor, school of nursing, University of Alberta. Born at Broad Valley, Manitoba, she received her early education in Winnipeg, and holds a Bachelor of Arts degree from the University of Manitoba.

A graduate of the Winnipeg General Hospital she did staff nursing there and in 1951-57 was the Director of Education and nursing arts instructor. Miss Tretiak spent seven years with the United Church Mission Board in Bella Coola, Kispiox, and Hazelton, British Columbia. From 1942-46 she was on the staff of Deer Lodge, Manitoba's Veterans Hospital, then spent three years with the City of Halifax Health Department. From 1957 until her present appointment she served with WHO as a nurse educator, post-basic programs, in Burma and Ceylon.

Active in nursing association work, Miss Tretiak has been a director of the MARN as nursing convener of both the Education Committee and the Nursing Service Committee. Leisure time activities include Alumnae work, Faculty Club, membership in *Kappa Delta Pi* and *Pi Lambda Theta* educational societies, reading, hiking, picnics and sewing. Church activities (missions) and music interest her; she is developing an interest in photography when she is not "whipping up a silly hat."

Jane G. MacKay has been appointed pub-

lic health nursing consultant in the Division of Public Health Nursing, Saskatchewan Department of Public Health. A native of La Fleche, Sask., Miss MacKay is a graduate of the Royal Jubilee Hospital, Victoria, B.C. She obtained a Bachelor of Science in Nursing degree from the University of Saskatchewan in 1957, and a Master of Arts degree from Columbia Teachers College in 1961.

She has served as a public health nurse in the Swift Current health region, assistant nursing supervisor in the Yorkton-Melville health region and in 1959, became nursing supervisor of the Melfort-Tisdale health region.

From 1943-46, Miss MacKay was a nursing sister with the R.C.A.M.C. and saw service in Canada, Italy, Holland and England.

The Saskatoon centre of Saskatchewan's Centralized Teaching Program has a new director, **Elisabeth E. Hartig**. Born in Markinch, Sask. she was educated in Saskatoon and Winnipeg. Miss Hartig received her basic nursing education at the Royal Victoria Hospital, Montreal, her post-basic education at the University of Western Ontario, where she was awarded a B.Sc.N. in 1952.

Becoming re-oriented to the Canadian scene and thought is occupying some of her time, after having spent 13 years in India. She was nursing superintendent at the Lu-



ELISABETH HARTIG

theran Hospital, Rajahmundry South India.

In her leisure time, she is active in church work, enjoys reading, music appreciation, travel, and sharing and interpreting her experiences in India. She is an amateur photographer and bird-watcher.



(Eaton's Portrait Studio, Toronto)

EDNA LAFLAIR

Edna Isabel (Clark) LaFlair is the new director of public health nursing for Prince Edward Island. A graduate of the four-year course leading to a diploma in public health nursing from the University of Toronto and the Toronto General Hospital, she recently obtained a certificate in P.H. administration from U. of T. Married soon after graduation, she returned to nursing ten years later.

As a school nurse in the Lakeshore area of Toronto Mrs. LaFlair was active in the organization of immunization clinics, child health conferences and classes in prenatal education. During the war years she was with the local branch of the Red Cross, serving as director of home nursing classes in the high schools and community and organizer of blood donor clinics. She was instrumental in instituting a Homemaker committee which was concerned with the home care of children and the aged. More recently, she spent a year as a research assistant with the School of Hygiene, Ontario Department of Public Health.

Mrs. LaFlair takes justifiable pride in her three sons who have all attended university, and her daughter who is presently enrolled in a university school of nursing. Her leisure-time activities have always been home-centred. They include music, reading, sewing, community and church activities.

Mary Ferguson, for many years the regional director of the Victorian Order of Nurses in Toronto, has retired. After graduating from the Victoria Hospital, London, she joined the VON. During her 32 years of service with the Order she worked in Liverpool, Nova Scotia, and in many parts of Ontario and Quebec. Of the 62 branches now serving those two provinces, she organized 14.

Her active nursing life left little time for pursuit of other interests. To this end, Miss Ferguson plans to take courses in current events, psychology and semantics at the University of Toronto. Although retired, the community will continue to benefit from her wealth of experience, since she will continue to serve on several committees dealing with public health.

After 38 years of nursing service, in Saskatchewan and British Columbia, **Matilda R. Diederichs** has retired. She is a graduate of St. Paul's Hospital, Vancouver, B.C. and holds a diploma in teaching and supervision from the School for Graduate Nurses, McGill University.

Miss Diederichs has taken an active part in nurses' association work, having been the first president of the Saskatchewan Catholic Nurses' Association, a member of the executive of SRNA from 1937-41 and president in 1941-45. She is a member of the Catholic Women's League, the Business and Professional Women's Club and the St. John Ambulance civil defence.

Her leisure time will now be devoted to travelling, reading and housekeeping.



MATILDA DIEDERICHS

THE WORLD OF NURSING



PREPARED IN YOUR NATIONAL OFFICE, CANADIAN NURSES' ASSOCIATION,
74 STANLEY AVENUE, OTTAWA

The Executive Meets

THE EXECUTIVE COMMITTEE of the Canadian Nurses' Association met in national office on February 8, 9 and 10. Highlights from national committee reports will appear in a later issue.

Vancouver — Convention City

Vancouver is the third largest city of Canada. Located in a setting of sea and mountain, the average summer temperature is in the low 70's. In Vancouver, you can dine on a mountain top or on the waterfront. It is an ideal city for a pleasure-filled vacation whether you prefer sailing, swimming, boat trips or just sitting and watching the beautiful seascapes. Shopping is a pleasure in Vancouver, the best in woollens, Cowichan Indian sweaters and rare English antiques can be found in the shops.

Avoid the rush! It would be appreciated if members who plan to attend the convention would immediately send us their completed "Registration and Hotel Reservation Form" that appeared in the January issue. Your early attention to this will ensure your desired accommodation.

Progress Review

Many members have been asking "What is the present position with regard to a program of accreditation of schools of nursing in Canada? What has happened since HELEN MUSSALLEM reported to the CNA biennial meeting last June?"

The CNA Executive, standing and special committees and working parties have done a good deal of work since June 1960 on the four recommendations in Miss Mussallem's report and

on resolutions which followed the report:

1. That a re-examination and study of the whole field of nursing education be undertaken.

DR. K. NAEGELE, has been appointed to make a survey of nursing education in Canada. Miss Mussallem will work closely with Dr. Naegele.

2. That a school improvement program be initiated to assist schools in upgrading their educational programs.

Decision to implement this program prior to the completion of the study suggested in Recommendation one, was made because representatives of all provinces indicated that considerable interest in such a program had been stimulated by the Pilot Project.

MISS GLENNA ROWSELL, formerly of Newfoundland, has been on national office staff to conduct this part of the program. The purposes have been stated as:

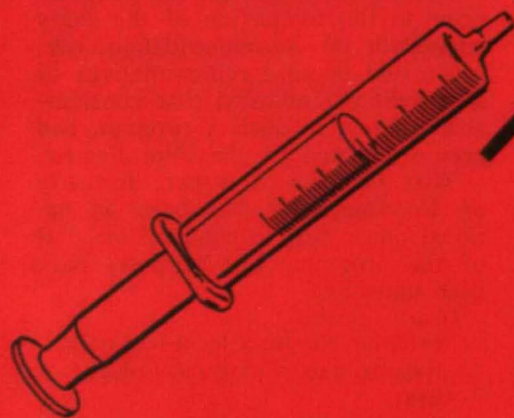
To assist schools:

- to identify the principles of (and work towards) a sound program of education;
- to initiate changes or improvements in harmony with such principles; and
- to apply these principles in preparing the type of practitioner of nursing that has been established as the objective of the school.

This program is focussed on self-evaluation by the schools. One hundred and fifty-eight hospital schools and three university schools have indicated that they wish to participate in this voluntary program and have completed a questionnaire as a first step in self-evaluation.

Regional conferences, held in each province for interpretation of the CNA School Improvement Program,

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No clamp—



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began in the fall and will end this month.

The purpose of these conferences:

- to interpret the objectives of this program to hospital administrations, boards of control and other appropriate administrative groups of the participating schools;

- to assist instructors of schools of nursing in evaluating their educational program through use of the Self-Evaluation Guide.

It is anticipated that the Self-Evaluation Guides will be completed by the staff of the schools of nursing by May 1962. These Guides will then be reviewed to ascertain the factors in the educational programs which require study and improvement. The staff of the schools will also be asked to identify areas of the educational programs in which they would like assistance. On the basis of this information regional workshops will be held (starting in the fall of 1962) to provide this requested assistance.

3. That a program be established for evaluating the quality of nursing service in the areas where students in schools of nursing receive their clinical experience.

Miss LILLIAN CAMPION, who has been a member of national office staff for some years, has been directing this project. In May 1961, she was awarded a Rockefeller Foundation Travel grant to permit her to visit various centres, in Canada and the U.S.A., for the purpose of learning about research studies concerning nursing which might be helpful in planning the project. These visits also provide Miss Campion with the opportunity to interpret to many Canadian nurses the purpose of and the preliminary thinking with regard to the nursing service evaluation program.

The Sub-Committee of the CNA Committee on Nursing Service acts in an advisory capacity to the CNA Project for the Evaluation of Nursing Service.

4. That a program of accreditation of schools of nursing be developed by the Canadian Nurses' Association.

The implementation of this last recommendation is still in the future. It will be recalled from Miss Mussallem's report "Spotlight on Nursing Education" (a report every nurse should read), that only 16 per cent of the schools participating in the Pilot Project would have qualified for accreditation if there had been such a system. The three programs now being implemented are a beginning towards improved nursing education and service, so that if a program of accreditation of schools of nursing is set up, more than 16 per cent of the schools will be able to qualify.

Membership

Canadian Nurses' Association membership figures show that as of May 31, 1961 there was a net increase of 2514 members over the number reported on that day last year.

	1960	1961
Alberta	4144	4361
British Columbia	6267	8289
Manitoba	2889	3528
New Brunswick	1956	2199
Newfoundland	830	886
Nova Scotia	2238	2357
Ontario	17608	21574
P.E.I.	387	441
Quebec	11698	13220
Saskatchewan	3370	3702
	57150	59664

Centennial Film

A new film on nursing will soon be in production. The Canadian Nurses' Association started proceedings for a film which will be one of a series for the Canadian Centennial produced by Crawley Films Limited.

The cost of the film, in French and English, will be spread over a five-year period. The specifications outline, concerning purpose, audience, scope and method, has been studied. It is hoped that an acceptable outline for script will be ready by this summer. A representative of the CNA will act as a technical director for the key sequence shots.

Following a surgical operation it is our duty to see that the scar on the mind is as

soundly healed as that on the body surface.

— EARDLEY BUTTON

Not my Fault but my Misfortune

CATHERINE SCOTT

Wanted! A minor miracle!

Every nurse has a grievance! Some want a shorter week — some a shorter day — not a few want more pay and no night duty. All of them want good food and longer holidays. All I want is to be able to hear!

I am not stone-deaf, in fact, I have only about 50 per cent hearing loss. But what a handicap it is in the world of nursing! Everybody regards it as a nuisance. There is no sympathy for it. Staff are too busy to keep repeating themselves; patients are too ill or too tired to make the effort. I cast no blame on anyone but why does it have to be me? It seems very wrong to grumble when there are so many blind and crippled people in the world. In my better moments I can thank God for my small cross of deafness, though there still remains the problem of earning my daily bread. But how am I to do it?

Eighteen years of nursing and three nursing certificates are of little use when applying for alternative employment. I know — I've tried. Besides, there is no substitute for the life if you are really devoted to the work. Factory machining is a dull diet after the rich

fare of relieving the pains and aches that flesh is heir to. The obvious choice for a nurse with loss of hearing is caring for old people, to which I have devoted six years of my life. But even the smallest homes have telephones, doorbells, and doctors' visits!

My actual nursing work has never fatigued me unduly but the energy that I have expended in getting within range of the bells, in making unnecessary visits to patients' rooms (in case they were ringing), and the worry that I have wasted all around has drained me of vitality. When I hear a nurse complaining of some trifling matter, like giving a little overtime or indeed of changing her off-duty, I want to read her a long, long lecture and tell her how lucky she is.

Perhaps some day soon the scientists will devote some of their skill to the creation of a hearing-aid that will give clarity as well as volume. That is one of my favorite day-dreams. I have another dream too. There will be big headlines in the newspapers — another new discovery. Some wonderful doctor has perfected an operation for the relief of nerve-deafness.

Cigarette smoking was associated with an increased risk of development of heart attacks, of death from coronary heart disease and from all causes in long-term population studies which were reported on at the American Heart Association's recent scientific sessions. The risk was more than twice as great in cigarette smokers ages 39-55, and a sample of the general population ages 30-59. It increased to greater than three-fold in the heaviest smokers.

The experience of cigar or pipe smokers and of those who had given up cigarette smoking, was called very similar to that of persons who had never smoked. The investigators reported that the effect of cigarette smoking appeared to be independent of cholesterol level, blood pressure and weight.

Heart Research Newsletter, Fall 1961

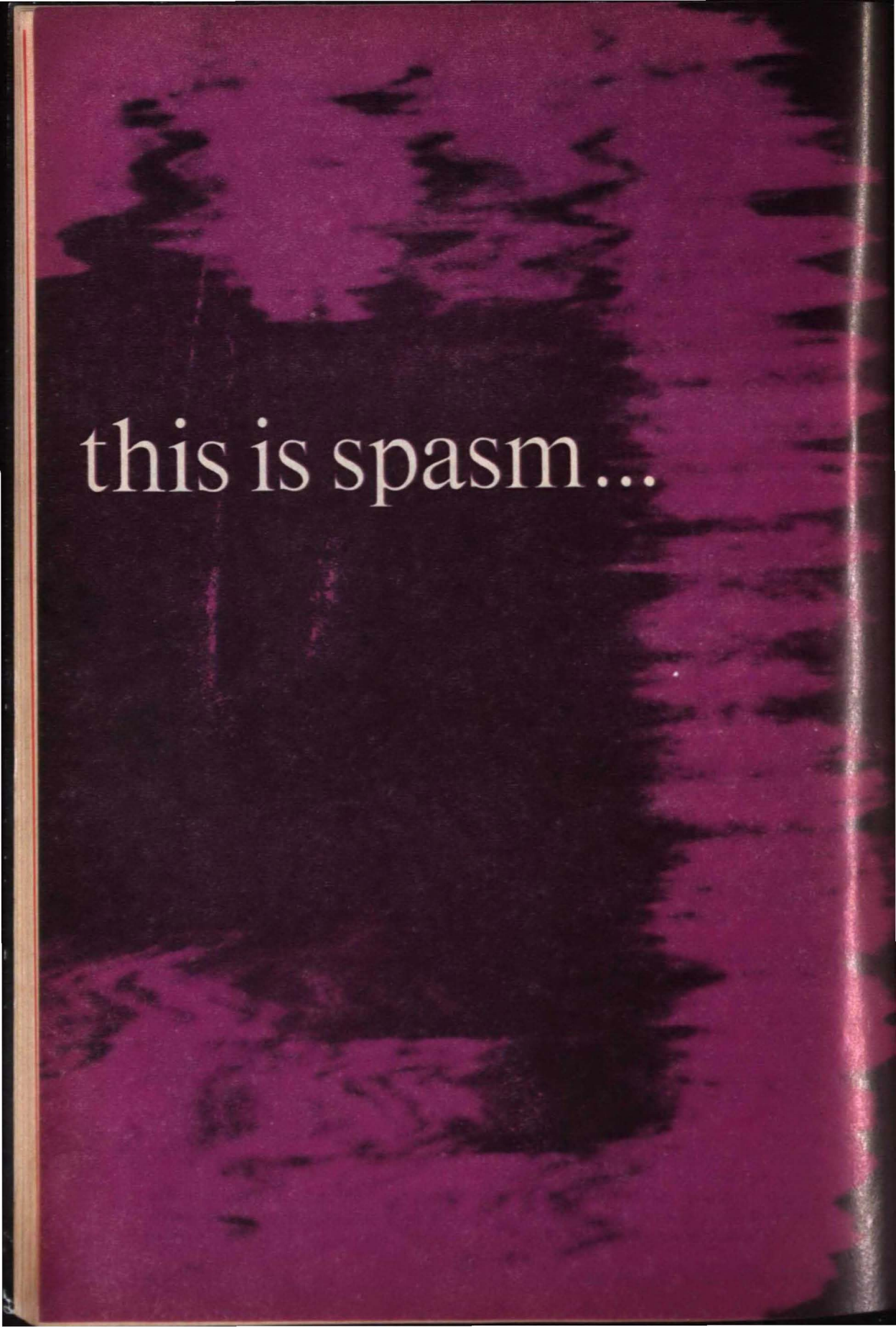
Most motorists are unfamiliar with carbon monoxide because it cannot be seen or smelled. To avoid carbon monoxide hazards:

1. Have your automobile's exhaust system checked periodically.
2. Always open garage doors before starting the engine.
3. Open a window if you have to stay in a stationary car with the motor running.
4. In closely-spaced traffic keep front air vents closed to prevent CO seepage from the exhaust fumes of other automobiles.
5. Stop, get out, and breathe some fresh air if you or any of your passengers feel drowsy.

* * *

I will have nothing to do with a man who can blow hot and cold with the same breath.

— AESOP



this is spasm...

this is **BUSCOPAN**

(N-butylscopolammonium bromide, Parke-Davis)

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BUSCOPAN blocks smooth muscle spasm wherever it occurs in the gastrointestinal, biliary, urinary, or genital tract. Its spasmolytic action is potent and selective. With a minimum of side effects, BUSCOPAN decreases hypermotility...relieves pain.

BUSCOPAN is highly effective in the treatment of gastric and duodenal ulcers, gastritis, cardiospasm, mucous colitis, spasm associated with various types of malignancy, and spastic constipation.¹⁻⁵ Functional biliary disorders associated with cholelithiasis, cholecystitis, cholangitis and pancreatitis also respond well to BUSCOPAN.¹⁻⁴ Moreover, this agent has proved useful in the management of smooth muscle spasm associated with disorders of the genitourinary tract,^{3,6} including dysmenorrhea.^{3,7,8}

In each of these spastic conditions, the usefulness of BUSCOPAN is enhanced by its virtual freedom from such commonly encountered side effects as sedation, dryness of the mouth, and visual disturbance.^{1,2,4-7}

Recommended dosage: 10 to 20 mg. (1 to 2 tablets) has been found to be the average single effective dose; however, dosage may be increased in acute conditions where pain is severe. A dose of 10 mg. three to five times a day is recommended for prolonged conditions such as peptic ulcer. *Supplied:* BUSCOPAN Tablets, 10 mg.—bottles of 100.

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Responsibility of the Nurse in the Control of Cross-Infection

CAROLEE E. BALCOM, B.S. and HELEN D. PALMER

How often is the nurse herself responsible for the spread of infection in hospitals? Is she aware that she is often instrumental in the spread of infection? More important, does the nurse know that infection is present, and is she equipped with the knowledge needed to prevent further cross-infection?

THE PROBLEM of cross-infection is receiving new stimulus through a questionnaire, entitled "Questionnaire on the Spread of Infection in Ontario Hospitals" that was recently sent out to all hospitals in Ontario, under the direction of Dr. W. H. le Riche, Professor of Public Health, School of Hygiene, University of Toronto. This survey is supported by a three-year grant for staphylococcal research, from the Department of National Health and Welfare, through the Department of Health for Ontario. It is designed to study the various aspects of hospital techniques.

The project is divided into three sections:

I. General Asepsis and Communicable Disease Control:

- (a) Non-isolation techniques
- (b) Isolation techniques

II. Housekeeping Techniques

III. Operating Room Techniques

The questionnaire is being sent directly to the hospital administrator. He has been asked to distribute the various sections among the staff or senior personnel in the different hospital areas. It is suggested that Section I be answered by a nurse or nurses in staff or supervisory positions; that Section II be completed by the hospital administrator himself, or be delegated to the executive housekeeper; and that Section III be answered by the operating room supervisor.

The questionnaire was drawn up with two purposes in mind:

- 1. To determine existing aseptic techniques in Ontario hospitals,
- 2. to bring into focus the need for improved asepsis, and to stimulate further thinking.

Although the program is sponsored by a grant for staphylococcal research,

it is the belief of the authors that any program that will aid in the prevention of staphylococcal illnesses, will in turn prevent the spread of many other communicable diseases. This paper, then, will be an attempt to focus attention on some of the existing aseptic techniques, with suggestions for change. We hope that this will provide the necessary stimulus to reawaken interest in one of the oldest and most fundamental tenets of good nursing care — the intelligent application of the principles of asepsis.

Prior to the time of Semmelweis and Lister there was no concept of asepsis. Patients, having the misfortune to be hospitalized, usually became sicker and in many instances died from some disease contracted as a direct result of hospitalization. Physicians of the day were helpless to control these diseases, and hospitals became enshrouded with a hopeless pessimism. Florence Nightingale faced this same situation when she arrived in Scutari in 1854. Her biographer, Cecil Woodham-Smith¹, in discussing the conditions of the Turkish Barracks, has written:

Sanitary defects made it a pest house, and the majority of the men who died there died not of the wounds or sickness with which they arrived, but of disease they contracted as a result of being in the hospital . . . the catastrophe which destroyed the British Army was a catastrophe of sickness, not of losses in battle.

Today, over a century later, we are faced with a similar situation. Hospitals have once again become a reservoir of infection.²

Following the advent of the "wonder drugs" two decades ago, there has been a gradual decline in strict adherence to aseptic techniques. The new

antibiotics gave physicians a false sense of security and the emphasis shifted from prevention to cure. Antibiotics were given routinely as a pre-operative prophylactic measure as well as being used for many non-specific illnesses. Through their widespread public distribution and indiscriminate hospital use, the efficacy of the antibiotics soon diminished. Related to the decrease in effectiveness has been an increase in the number of penicillin-resistant staphylococci. Thus, today, we are faced with the problem that confronted Lister a century ago — the elimination of microorganisms *before* they can enter the body.

Nurses are the largest single group trained in the principles of aseptic techniques. For this reason, they should assume responsibility for the instigation and enforcement of such techniques.

The fact that asepsis is not being adequately practised today is clearly shown in a study by Caswell *et al.*² at the Temple University Medical Center. They found that the majority of staphylococcal infections among hospital personnel occurred in student nurses who have the most intimate contact with patients. Two-thirds of these infections occurred on parts of the body which were uncovered and exposed to direct contamination.

It is generally accepted that aseptic techniques are based upon a sound knowledge of microbiology. If the nurse is to be an effective participant in any infection control program she must be aware of the organism causing the disease and its mode or modes of transmission. It is necessary for her to know what secretions or excretions harbor the infective agent if sound disinfection is to be carried out. She must know the length of time a given disease is communicable, and whether or not the patient could become a carrier. Unless the nurse has an intelligent understanding of these concepts, she will not only be unable to protect her patient, but in turn will be unable to protect herself from disease.

Unfortunately, few nurses possess the adequate knowledge necessary to control the spread of disease. Thompson³ points out that microbiology is taught too early in the curriculum as part of some comprehensive course.

Students are bombarded with myriads of facts, many of which are not remotely related to their concept of nursing practice. As a consequence, the important details of microbiology are promptly forgotten as they have no practical application for the nurse. What is needed is an introductory course in the subject that is specifically related to the actual practice of nursing. Unless a science can be applied, it becomes merely a mass of unrelated facts.

Another factor that may be contributing to this lack of appreciation of the importance of asepsis is the decline in student experience in infectious disease hospitals. The emphasis has shifted from infectious diseases to mental diseases with the result that fewer nurses are receiving specific instruction in the proper application of aseptic principles. Along with this shift has come the subsequent attitude that communicable diseases have been conquered. This is clearly a failure to realize that no infectious disease will remain dormant for very long unless continuous control measures are instituted.

The term *asepsis* is often understood as implying those techniques carried out when caring for patients with known communicable diseases. This is misleading because *aseptic techniques are an integral part of every aspect of nursing practice*, based on the time-honored concept of assiduous cleanliness. Moreover, the greatest concern about disease spread should not be in an area set aside specifically for the control of spread of infections. Rather, it is in the far greater area of the hospital where possible infections may lurk undetected.

Much of nursing is still based on ideas that are traditional and outmoded. Numerous articles have been published in medical journals regarding the problem of the staphylococcal carrier, indicating that the sites of carriage of this organism are the nostrils and the anal region. Yet, cloth bedpan covers continue to be used rather than disposable ones. The sterilization of bedpans thus becomes a purposeless ritual if the newly sterilized pan is to be again covered with a contaminated cover.

Blankets, pillows and mattresses

have all been shown to harbor pathogenic organisms. Too often, they are only haphazardly disinfected, if at all. Unless mattresses and pillows are covered with an impervious cover, it is not sufficient merely to wipe them with a disinfectant. In some hospitals, blankets are even stored in a warming closet after use thereby possibly incubating the organisms.

Another example of this traditional passive acceptance is in the technique used for disinfecting thermometers. Studies have shown that certain disinfectants are inactivated by soap, one of these being Zephiran, a widely used thermometer disinfectant. Again, nurses traditionally continue to cleanse thermometers with green soap and water before placing them in the disinfectant. Few nurses are concerned about completely removing all traces of the soap, with the result that instead of being placed in an effective disinfectant, thermometers are often stored in an innocuous mouth wash. This mouth wash may become a culture medium for bacteria, rather than a disinfectant.

Dressings are still being changed with too little observance of aseptic principles. They are often done on wards at the same time that the housekeeping staff is busily stirring up dust and pathogenic organisms. It has been shown that patients who are nasal carriers of staphylococci may infect their own operative sites. Yet patients are seldom if ever required to wear a mask to protect themselves from auto-infection when dressings are being done.

Again, it has been shown that patients with septic lesions or staphylococcal pneumonia disseminate pathogenic organisms over a wide area. Yet, in many hospitals today, frank cases of staphylococcal infections are seldom if ever isolated. Frequently, medical personnel themselves continue to work even when they have open and draining staphylococcal lesions. It has been shown that the highest incidence of staphylococcal infections are found among patients already suffering from some debilitating disease, due directly to their increased susceptibility. The failure to appreciate the

seriousness of the situation and to apply sound aseptic principles is directly responsible for the increase in staphylococcal infections.

The responsibility for the prevention of infection must become the concern of every hospital department. The war against cross-infection cannot be the private war of any one group. Nurses have been quite willing to relinquish many of their former responsibilities in the area of hospital housekeeping. Today, many of these tasks are being carried out by persons with little or no training in the principles of asepsis. It is our conviction that the role of the housekeeper is a prime essential in the over-all control of cross-infection. Nurses must prepare to resume more of the responsibility in the area of hospital housekeeping. They must not only be willing to train the housekeeping staff in the principles of asepsis, but also be willing to provide guidance on the ward. For, unless the concepts of disease spread and control are made known to everyone concerned, hospitals will continue to be a source of infection.

It was nearly one hundred years ago that Florence Nightingale, wrote:

It may seem a strange principle to enunciate as the very first requirement in a hospital: that it should do the sick no harm.

That concept is as vital today as it was almost a century ago. It is only through the understanding and practice of aseptic principles that infections can be controlled. This, then, is the responsibility of nurses today.

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... My age is like the lusty winter, frosty but kindly. — SHAKESPEARE

Nasal Carriage of Staphylococcus by Operating Room Staff

CAROLINE MARTIN

A report of a study of the incidence of organism carriers among staff members in an operating theatre.



IN 1954, a study was begun of the cause of wound infection at Shouldice Surgery, Toronto, comprising two hospitals 10 miles apart. One, referred to as "Church Street," is the older and is in the central part of the city. The newer hospital is outside the city limits and is referred to as "Thornhill." In 1954, Thornhill had much the higher rate of wound infection although both hospitals do exactly the same kind of surgery (herniorrhaphies) under the exactly similar nursing and surgical supervision.

Some interchange of operating room staff takes place between the two hospitals but nothing was known about the carriage of infection from one to the other. One surgeon, Dr. A, had been at Thornhill all through 1954. He was transferred to Church Street early in 1955. At once the Thornhill infection rate fell and the Church Street rate rose. The rise occurred when several of Dr. A's cases became infected; at one point he had nine infected wounds in ten operating days. In the same ten days, a second surgeon, Dr. B, performed an equal number of herniorrhaphies in the same operating room under exactly the same conditions with no infected wounds. It was concluded that Dr. A was somehow concerned in the introduction of infection at the time of operation although there was no difference in surgical technique or sterile precautions.

Dr. E. E. Shouldice therefore devised a special modification of an air force mask so that expired breath from Dr. A was only permitted to escape by a tube down his back, following which he was able to continue operating with a greatly reduced infection rate resulting.

Nasal Swabbing

By 1955, it had become well-known

that pathogenic staphylococci could be found in the nares of hospital staffs. From 1956 to 1958 the study was concentrated on the surgeons, and the bacteriology of their nasal passages, because they came in closest contact with the wounds. A more extensive report on this work by Dr. A. F. Browne, resulted in a realization that the investigation would have to be extended to other members of the operating room staff — the assistant surgeons, scrub nurses, etc. By 1959, the number of nasal swabs being processed became too great for the Ontario Provincial Laboratory to cope with. It was necessary for Shouldice Surgery to build its own bacteriological laboratory.²

The blocked graph (Fig. 1) tabulates the great number of nasal swabs taken over a period of eight months from all surgical staff who might be breathing near open wounds. A study of the graph shows that some were constant carriers, some less constant and (surprisingly) that some were persistent non-carriers, despite the taking of hundreds of swabs.³

Study and Definition of Wound Infections

The study of wound infections is complicated by the fact that, since 1945, early ambulation and other measures of postoperative care have enabled patients to be discharged from our hospital on the third postoperative day after a hernia repair. This is often too early for signs and symptoms of wound infection to have appeared. Although our infection rate is low compared with many general hospitals, it became a matter of concern to us that patients were beyond our observation by the time their infections came to light. We seldom had the chance of giving early treatment with antibiotics, etc. This concern intensified our efforts

1960. I was also often a circulating nurse and sometimes a scrub nurse in the operating room.

In the course of this six-year study, it was found that I was among the transient nasal carriers of pathogenic staphylococci and, in fact, my nasal swabs were persistently positive from 1955 to 1957. At first this was not a matter of concern because the staphylococci from my nose were non-typable by the bacteriophage typing technique, whereas the staphylococci grown from infected wounds were always phage-typable. But in late 1957 non-typable staphylococci began to appear occasionally in wounds. I realized that I might be a source of wound infections. Yet I was in good health with presumably good bacterial resistance and my nasal cavity appeared to be normal and free from obstruction or deformity.

Early in 1958 a ten-day holiday was taken on the Atlantic coast. Immediately upon return by air, and before going home at all, fresh swabs were taken at the Ontario Provincial Laboratory. These swabs were negative for pathogenic staphylococci, the first negative swabs from my nose in three years. This showed that I was not a "constant" carrier. It was thought that the most likely source of exposure might be my home surroundings. I was instructed to swab the noses of my daughter, my mother-in-law and my father-in-law with whom I lived. My father-in-law was ill and his breathing was obstructed by asthma and nasal polyps. His doctors advised against removal of the polyps because of his age and his asthma. He was always blowing his nose and probing it to try to get relief. It was his nose that proved heavily contaminated with *Staphylococcus aureus* hemolytic coagulase-positive, the self-same microorganism that had been found over the years in my nose. It was indistinguishable, by any bacteriological technique including antibiotic sensitivity tests and bacteriophage typing.

Culture plates exposed in his room were also positive for the same staphylococcus though sometimes, if his room was irradiated with ultra-violet light the plates would be negative.

It was a daily occurrence for me to visit my father-in-law in his room.

We seemed justified in concluding that my nose was being re-infected daily from the air there. Thus, a nurse working in close association with open wounds was possibly contaminating them as a result of her nose being re-infected daily from a source outside the hospital.

Attempts were made to verify this daily re-infection of my nose from home surroundings by swabbing it as soon as I arrived at either hospital after setting out from my home. These swabs were always positive. Then it was arranged for me to sleep at the hospital (so that I was away from home at least 24 hours). Swabs taken just before leaving the hospital were negative, the procedure being repeated on ten occasions with the same result. This seemed to establish not only that I was an intermittent or transient nasal carrier of pathogenic staphylococci but also that my nasal secretions seemed to be bactericidal to them. Furthermore, during periods of my father-in-law's admission to a hospital the culture plates exposed in his room at home and the swabs taken from my nose both became negative. Swabs taken from his nose when he was in the hospital remained positive as they had been at home. Finally, he died in April 1960. Since then my nasal swabs have been constantly negative, although at first up to five were taken daily. One would be taken on arrival at hospital and one after each of four operations during which I had been a circulating nurse in the operating room. Later only one daily swab was taken and recently only one a week. Altogether 150 swabs have been negative over the past year.

Discussion

This report concerning a nurse carrying pathogenic staphylococci from her home surroundings to the hospital was submitted for publication because no similar report could be found in a search of the medical literature.

It must be admitted that despite all this work we have not been able so far to correlate the staphylococci cultured from an infected wound specifically with the staphylococci from the nares of any particular doctor or nurse who was in the operating room when that wound was exposed. However,

the work is continuing and we hope ultimately to be able to shed some light on the relationship between staphylococci from infected wounds and those from known nasal carriers composing the responsible operating team.

An unknown factor still exists in the periodic rise and fall of the wound infection rate. In July, 1960 one wound became infected after 316 herniorrhaphies, or 0.3%: in August, 1960 there were 6 in 245 herniorrhaphies, or 2.4%.

The day may come when operating room staff are chosen as much for their freedom from being nasal carriers of staphylococci as they are for their ability to perform their duties. If operating surgeons and their staffs are going to operate, regardless of the nasal carrier state, the only hope of reducing wound infection would seem to lie in the provision of ultra-violet light in the operating room. This has been demonstrated by the Medical School of Duke University in Durham, North Carolina and described by Professor D. Hart.⁴

This study has shown no ground for criticism of the nurses working in, or having supervision of the operating rooms and no evidence whatever of wound infection arising from defective autoclaving of supplies such as drapes, gloves, solutions, etc., or other procedures carried out in the operating room by the nursing staff.

Conclusions

1. An individual surgeon may infect his surgical wounds from his own nose. When he is shown to be a persistent nasal carrier of virulent staphylococci he should be required to wear a special mask to prevent him from breathing onto an open wound

until such time as his nasal swabs become negative.

2. Surgical assistants and scrub nurses may also infect wounds while present at an operation.

3. Virulent pathogenic staphylococci may be brought into the surgical department from sources outside the hospital by unsuspecting staff.

4. An unknown factor, or factors, are postulated in the observed rise and fall of wound infections.

5. A high rate of wound infection in general hospitals will not be reduced until serious attempts are made to eliminate pathogenic staphylococci from nasal carriers who have close association with open wounds.

6. The use of special masks for nasal carriers of virulent staphylococci is essential.

7. Failure of nursing techniques in asepsis and sterilization of supplies has not been found a factor in producing wound infections in this study.

Acknowledgement: On my own behalf and on behalf of Shouldice Surgery, I should like to express thanks to the Ontario Provincial Laboratories for their courtesy and cooperation, without which this study would have been impossible.

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Coming!

IN MARCH 1962

Guest editor — Glenna Rowsell, Director,
CNA School Improvement
Program
Ireland — British Columbia

Martin and
Prange — Human Adaptation
Falardeau — The Hospital Nurse in a
Changing Society

plus additional material

Upper Extremity Prostheses for Children

EILEEN J. MAYO

For many years the medical profession and workers in the rehabilitation field found that it was a very difficult problem to persuade children to wear upper extremity prosthetic appliances. The nurse can help both the parents and the child to accept and use an artificial limb.

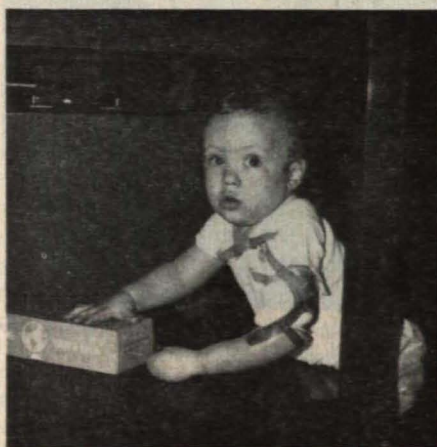
UNTIL RECENTLY the application of appliances following amputation was generally postponed until the child commenced school, or until he was old enough to decide that he wanted such an appliance. This was usually when he reached teen-age and began to realize how different he was in appearance and capability from his contemporaries, and how this was to affect his later life.

Specialists who deal with amputees have felt that, whether the cause of amputation was congenital or traumatic, the earlier the child is fitted with a prosthesis the better. In the young child's daily activities, his skill with and uses of the appliance will be developed to the maximum. He will become steadily more natural in using it until it ceases to be a problem. When a child is not fitted until he is older there is possibility of atrophy and contractures due to non-use of the affected muscles. Children who have not been fitted with an appliance until later in life usually reject it. This is one of the causes for never wanting to learn to use it correctly and to its full advantage.

It will be realized that there is a considerable difference between fitting and training a child and an adult. It is interesting to note that the age of the child when the trauma occurs has a great bearing on his adaptability. It has been observed that the acceptance of the prosthetic device and its utilization varies with the child's individual mental capabilities.

The Prosthetic Appliance

The majority of specialists are now fitting congenital upper extremity amputees soon after the age of five months. The infants are fitted with a "mitten," a passive device having no moving parts. It is a pink plastic mitt that is usually very acceptable to the



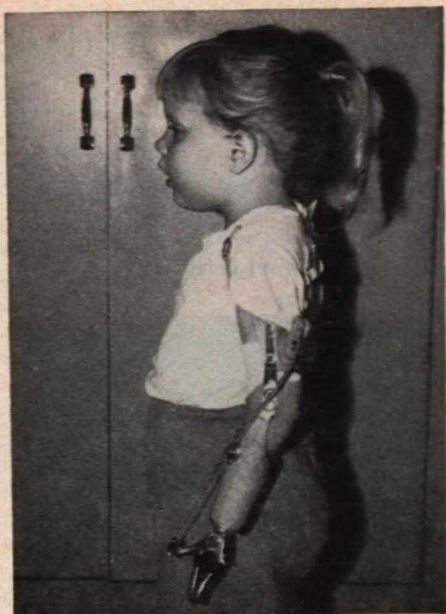
Mitten type of terminal device worn by an infant.

mother as it is cosmetically appealing and appears like a normal hand when seen from a distance. This type of appliance is provided for children with a below-elbow amputation and is held on to the upper arm by a figure eight harness across the shoulders to the normal side.

This gives the infant two arms of equal length. From the age of six or seven months, he will use this appliance to balance himself in a sitting position. It will later enable him to crawl. By 22 months he can use the mitt to assist himself in such daily activities as eating — by pushing the food onto the spoon — and holding his cup. This appliance should be worn during all the infant's waking hours.

When the child is between 24 and 30 months, he can be fitted with a functional arm which will have a grasping device — a voluntary opening hook operated by a single control cable system. Now, for the first time, the child has a means of grasping an object.

A more complicated type of hook will be supplied when the child becomes more capable of using this type



Simple hook type of terminal device for grasping objects.

for grasping. He will be able to dress and undress himself with greater ease. He will become more and more adept at handling a knife, fork and spoon. He will be able to take part in practically all the activities out-of-doors which his playmates are capable of performing.

When the child reaches 13 or 14 years, he may be fitted with a hand and cosmetic glove. This is supplementary to the hook and is usually worn for social occasions. More recently, attention has been directed to the use of carbon dioxide compressed cylinders to produce elbow movements, forearm rotation and finger and thumb approximation.

Providing prosthetic devices for bilateral amputees creates a very special and difficult problem. Because of the weight of the appliances it has been almost impossible to equip and train a child with any degree of satisfaction. Specialists are devoting considerable time and thought to this particular aspect.

Traumatic Amputation

The child who has had to have an amputation may realize he faces a triple threat: a loss of part of his body, a loss of function that the limb has heretofore provided, and the loss of his place in society. He is wonder-

ing what will happen to him. Will he eventually be able to earn his own living? What will his family and friends think of him? These anxieties can be helped in many ways. The observation of other amputees is very important. The child sees them doing things that he wants to do but cannot. As a result he is more willing to accept a prosthesis. The parents, too, will more readily accept the appliance when they see others with similar and, in many cases, greater disabilities developing new skills. If it is impossible for these children and their parents to meet other amputees, movies or slides can be equally helpful.

Training the Child

Proper training is most important once the child has been fitted with a prosthesis which is made especially for him. This program has been greatly neglected until recently.

In order for a complete rehabilitation program to be effective, it is essential to have a team composed of physicians, therapists, prosthetists, nurses and social workers. This is vitally important because the physician will know how to prescribe, the therapist how to train, and the prosthetist how to manufacture the prescribed appliance. Nurses and social workers will help the child, his parents and his friends accept the new device. So that the child gets the most use from his prosthesis, it is essential that it be in good working order, that worn parts be replaced, and that it be altered or replaced as the child grows. Periodic checking and re-evaluation by this team for the fit of socket, alignment and length of prosthesis are important. The child must also be checked at regular intervals to see if there is need for further training in activities that may be related to his future vocational plans.

The age and type of amputee will determine the course of training he requires. In the very young, the training is adapted toward the simple activities of the child's age. If he is older, the training efforts become more involved to perfect the motions required in activities such as eating, writing, dressing, opening and closing doors, and other aspects of daily living that are normally done without giving

thought to the action involved. The goal in every case is to encourage and train the child in the proper and efficient use of his artificial limb, and restore, insofar as is possible, his normal physical capacity.

In the very young child who is fitted with the mitten type of device, in-service care for fitting and training may require approximately 16 days. When the child is able to learn to use the voluntary opening hook, a second period of training is necessary. This may last from 15 to 21 days.

The cost of these devices varies from the mitten type, which is approximately \$100, to the more complicated functional and cosmetic hand, which may cost as much as \$350. Added to the cost of the actual prosthesis is the charge made for follow-up service, replacement of parts that become worn and broken. New devices are required from time to time as the child grows. It has been estimated that the expenditure for appliances, maintenance and labor, for a 19-year period, amounts to \$2300.

The Parents' Role

The emotional shock to the parents who realize that their child has either a unilateral or bilateral amputation of an upper extremity is rarely understood. In some cases it may be so severe as to affect the life of the entire family, as well as that of the child amputee. The despair, depression and anguish of the parents are expressed in many ways. They wonder why and how this could happen? Is it a punishment for some sin committed in the past? Resolving these guilt feelings may require many hours of psychological assistance.

In addition to the physician, therapist, nurse and social worker, the role played by the parents is most important in the complete rehabilitation of the child amputee. Their acceptance of the device will prove of immeasurable benefit. They must insist that the child wear his limb as much as possible. They have to learn not to do things for him but to let him learn to do as much as possible for himself, even if it takes a little longer. The only way the child will learn how to use the prosthesis is by using it. The parents must not allow the new wearer to be-



Cosmetic hand provided for the older child.

come one-handed, but should encourage him in activities which require the use of both hands. In order to fully understand how to help the child with the device the parents must fully comprehend the mechanism of the prosthesis. This will be explained to them in great detail by both the prosthetist and the therapist.

Although the prosthesis should be worn as much as possible, there are certain conditions under which it may be removed. In certain strenuous games, wearing the device might endanger other people so it is advisable that it be removed. A device may also be taken off at bedtime or when the child has a nap, if this will make him more comfortable. It is most important that the parents see that the stump is kept clean by washing it at least twice daily, and that the artificial limb is also kept clean and in good repair at all times.

The social adjustment of the child is particularly difficult when he begins school. For the first time he will meet people who will notice that he is different. His first day at school, whether he is just starting or returning after his amputation, is vitally important to him.

The child's mother should accompany him to school the first day. The cooperation of the teacher should be assured before the child enters the classroom. The teacher should explain the disability to the other children and ask the child to show his classmates how the prosthesis works. Once children understand a particular disabili-

ty and what the prosthesis will do to rectify it, they will readily accept it.

Phantom Limb Sensation

According to Dr. C. H. Frantz, Michigan Crippled Children Commission, the phantom limb sensation disappears if amputation occurs when the child is younger than eight years of age. If amputation occurs from eight to ten years of age, sensation of the missing member can be brought back. After ten years, it lasts indefinitely. If the phantom limb phenomenon is due to a neuroma, it should be resected and a sheath of polyethylene placed over the end of the nerve to prevent recurrence.

Conclusion

Our present goal for child amputees is to make provision for early fitting of prosthetic appliances, supply adequate training to insure their proper use, and to encourage parents' partici-

pation in acceptance. In this way, and through the normal process of learning, we hope these children will develop self-reliance and be completely independent without any feeling of inadequacy. Amputees are gainfully employed in countless occupations — as school teachers and farmers, in industry and business offices, and as successful homemakers.

Is this the complete answer to the wearing of prosthetic appliances? We think not. If scientists are capable of sending space ships to the moon and even further, surely an appliance can be devised that is not only functional but, equally important, cosmetically appealing. Until such time, it is doubtful if children will ever readily accept a device that makes them so obviously different from their playmates.

Photographs are provided through the courtesy of Dr. Carleton Dean, Director, Michigan Crippled Children Commission.

IN THE GOOD OLD DAYS

(*The Canadian Nurse* — FEBRUARY, 1922)

The administration of a general hospital fifteen or even ten years ago was quite a different problem from the complex situation that exists today . . . The old, careless, happy-go-lucky methods of conducting our charitable institutions in the past have given way to modern business methods. We look upon our hospitals now as large factories; our product is not boots and shoes but *health*. Our various departments all contribute to the manufacture of that product; not the least important, if not the most important department, is the training school.

* * *

The yolk of a raw fresh egg is recommended in the feeding of a baby that is not thriving. One should be mixed with the feedings each day.

* * *

The relationship of the nurse to the physician in charge of her patient is something more than that of an assistant. It is better defined as the relationship that exists between the commanding officer and his adjutant, with all that is implied in the way of initiative on the part of the junior officer.

The essence of the thing should be loyalty on the one hand and consideration on the other, both fully cooperating in the interest of the patient.

* * *

Postoperative distention is much easier to prevent than it is to cure. In this prevention, we find the administration of digitalis most valuable. How or why this occurs is open to discussion. Aside from its undoubted action on the heart and circulation, we believe that digitalis has a direct action on the intestinal musculature as well as through the vagus. After its use we have no difficulty in getting bowel action, and whereas formerly we frequently prescribed pituitrin and eserine, we now use them only occasionally. The digitalis is introduced into the Murphy drip that is started immediately on the patient's return to bed.

A plausible impossibility is always preferable to an unconvincing possibility.

— ARISTOTLE

Let's Make Our Flag Official

The one important fact that seems to escape notice in every controversy about a Canadian flag is that Canada already has one — the Red Ensign. As the Encyclopedia Canadica says, it is "legal and widely recognised . . . abroad." Canada has just neglected to make it the official flag at home. Let's make it official.

A common argument against the Red Ensign is that Quebec would oppose it, and that it would therefore divide rather than unify the nation. The truth is that only hypersensitive nationalists in any part of Canada would cry out against it. And once it became the official national flag, the nation would accept it. In fact, it does so already.

Outside Canada it is generally accepted as the Canadian flag. Small wonder, for it was made legal to fly on Canadian buildings abroad by act of Parliament as long ago as 1924. It flies over Canada House in London, over Canadian embassies throughout the world. It has been carried into lands from Finland at the top of the earth to Australia

at the bottom by Canadian Olympic teams. It has been carried into battle by Canadian forces from Hong Kong to the Rhineland.

It is a good flag, recognized as typically Canadian. It carries on the fly the Canadian coat of arms, embracing the symbols of the four great traditional nations of Canada's origins — England, France, Ireland and Scotland — and, for good measure, a cluster of maple leaves.

It has become increasingly obvious that a succession of governments has intended to go on using the Red Ensign as a distinctive Canadian flag until it becomes *the* Canadian flag by common usage. It was given approval just short of statutory recognition by an order in council of Sept. 5, 1945. Earlier, it was flown from the Peace Tower on V-E day and until sundown the following Sunday in place of the Union Jack.

Common usage and worldwide recognition have made the Red Ensign Canada's flag. The time has come to recognize it in the statutes. — *Toronto Telegram*

From *'Letters of Elizabeth Barrett Browning'* compiled and edited by Fred G. Kenyon.

To Mrs. Anna Jamieson, author and critic, — noted authority on sacred art.

I know Florence Nightingale slightly.

She came to see me when we were in London last; and I remember her face and her graceful manner, and the flowers she sent me afterwards. I honor her from my heart. She is an earnest and noble woman, and has fulfilled her duty where many men have failed.

At the same time I confess myself to be at a loss to see any new position for the sex, or the most imperfect solution of the "woman's question," in this step of hers. If a movement at all, it is retrograde, a revival of old virtues! Since the siege of Troy and earlier, we have had princesses binding wounds with their hands; it's strictly the woman's part, and men understand it so, as you will perceive by the general adhesion and approbation on this late occasion of masculine dignities. Every man is on his knees before ladies carrying lint, calling them "angelic she's," whereas, if they stir an inch as thinkers or artists from the

beaten line (involving more good to general humanity than is involved in lint), the very same men would curse the impudence of the very same women and stop there.

I can't see on what ground you think you see here the least gain to the "woman's question," so called. It's rather the contrary to my mind, and, anyway, the women of England must give the precedence to the "soeurs de charité," who have magnificently won it in all matters of this kind. For my part (and apart from the exceptional miseries of war), I acknowledge to you that I do not consider the best use to which we can put a gifted and accomplished woman is to make her a hospital nurse. If it is, why then woe to us who are artists! The woman's question is at an end. The men's 'noes' carry it. For the future I hope you will know your place and keep clear of Raffaele and criticism; and I shall expect to hear of you as an organizer of the gruel department in the hospital at Greenwich, that is, if you have the luck to percer and distinguish yourself.

About Books

Nursing in Tuberculosis by Louise Lincoln Cady, R.N., B.S., M.A. 489 pages. McAinsh and Company Limited, 1251 Yonge Street, Toronto 7. 2nd ed. 1961. Price \$6.50.

Reviewed by Miss Mary Rowles, Director of Nursing, Royal Inland Hospital, Kamloops, B.C.

The name of Louise Lincoln Cady is so well-known to Canadian nurses that it is hardly necessary to introduce the author of this book. For those working with tuberculosis patients, her text has become required reading. Its usefulness cannot be overestimated.

For this edition of her book Mrs. Cady has gathered material from far and wide to present a truly broad picture. Of particular interest to Canadians is the fact that many of the illustrations and forms were furnished by the Division of Tuberculosis Control in British Columbia. Their inclusion in an American textbook is an example of the exchange of ideas between professional groups on both sides of the border, and one of which we may well be proud.

In the interval since the first edition was published the picture of tuberculosis control has been almost completely changed. The impact of this situation on the nursing care of tuberculosis patients has been immense. All personnel associated with this work have had to revise their thinking and skills. The fact that the nurse is a member of a team of specialists, all engaged in planning the care of the patient, and that the patient is also a member of a group is emphasized by the author. The role of the tuberculosis hospital in relation to the patient, his family and his community, and its liaison with other agencies, points up the possibilities for skilled and sympathetic nursing care inherent in the daily relationship with this type of patient.

New methods are discussed in detail but older treatments and procedures are not neglected. The chapters on surgical treatment are explicit and complete. Frequent references are made to the advantages and disadvantages of home care for tuberculosis patients, and to the significance of this program for the public health nurse. Chemotherapy is interpreted in a concise table, which gives complete information about each drug. This should be a valuable teaching aid.

As well as being factual, the book has been written in an easy-to-read style that holds the interest. It is a most conscientious and thorough review of a subject that should hold dynamic interest for all nurses. Mrs.

Cady has infused new life into her subject. She has provided the material whereby each nurse may evaluate her contribution to the care of the tuberculosis patient.

Teaching Psychiatric and Mental Health Nursing by Marguerite Lucy Manfreda, R.N., B.S. 384 pages. The Ryerson Press, 299 Queen St. West, Toronto 2B. 1961. Price \$9.50.

Reviewed by Miss Mary Wrinch, Instructor, School of Nursing, Vancouver General Hospital, Vancouver 9.

In this, the first text designed for use by teachers of psychiatric nursing, the author's stated aim is to assist in the "development, administration and teaching of an undergraduate, professional, psychiatric nursing affiliation program." Her hope is that the material presented will "lead to new ideas and better programs of instruction in nursing, particularly psychiatric and mental health nursing." Miss Manfreda has succeeded well in achieving her objectives. The book should prove useful not only to instructors of psychiatric nursing at both the professional and practical nurse level in mental hospitals and psychiatric units of general hospitals, but also to mental health coordinators, and to those concerned with planning total experiences for basic nursing students, especially in situations where attempts are being made to integrate mental health concepts into the entire program.

The author develops her topic clearly and logically. She covers the groundwork that must be completed before establishing affiliation programs. She discusses the curriculum content and selection of learning experiences that are carefully related to the philosophy and objectives of the program. In dealing with curriculum content, the consideration of the *descriptive* as opposed to the *pattern* approach to psychiatric disorders is excellent. The advantages and disadvantages of each are weighed and suggestions for reconciling the differences are made. The sequence of learning is well dealt with also. Methods of teaching, both the familiar and the less familiar, are clearly described with useful examples of each that are easily adaptable to a variety of situations. Evaluation is thoroughly considered from both theoretical and practical aspects. This process, which is particularly difficult in psychiatric nursing, is made much clearer.

The chapter dealing with integration of sociopsychosomatic concepts in the basic

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nursing curriculum not only defines and justifies this process but, once again, makes highly practical suggestions as to how it has been or may be accomplished. Social psychiatry and its implications for nurses, patients and the public is well discussed with consideration of the needs of all these groups. The text concludes with a chapter concerning examination questions with examples; information in relation to research, always necessary but sometimes forgotten; practical consideration of budgets; equipment for and cost of programs; samples of printed forms necessary to facilitate administrative and teaching programs. Throughout the book, one is impressed by the application of basic principles of learning and teaching as they are applied to a specific field, and the consideration given at all times, not only to the learners and those to whom they give care, but also to those responsible for fostering and facilitating the learning process. This book should prove a valuable contribution to nursing as a whole and therefore to society.

Study Guide for Clinical Nursing. Prepared under the direction of Emily C. Cardew, R.N., M.S. 557 pages. J. B. Lippincott Company, 4865 Western Ave., Montreal. 2nd ed. 1961. Price \$6.50.
Reviewed by Mrs. Peggy Mika, Clinical Coordinator, St. Joseph's Hospital, Victoria, B.C.

In preparing this second edition the purposes of the text have not been changed. It

"presents a method of organizing materials which will help students to synthesize and to apply the principles of the biologic, the physical, and the social sciences in understanding and meeting the individual patient's need."

A few important additions have been incorporated. Each section has an overview that serves as an introduction. A section on fundamentals of nursing has been included. This unit is a basis for all other units in the book and would be most helpful to instructors of first level students. The inclusion of material on home care of the patient, and care of the patient in industry and at school is timely, in view of the present emphasis on the public health aspect of nursing.

This text has value for two main groups. The clinical instructor, especially if she is just starting her career, will find the patient studies of great help in organizing patient-centred teaching. They form a basis for group discussion. The excellent bibliographies give added resource material for the instructor as well as for student assignment. The senior student can organize her review for final examinations by utilizing the "Study Guide" as well as her own texts and notes. However, students often need guidance in the use of this type of reference, as they tend to memorize the questions rather than test their own knowledge of the application of principles. This text should be a part of every well-stocked school of nursing library.

He is very fond of making things which he does not want, and then giving them to

people who have no use for them.

— ANTHONY HOPE

Other Publications

Personal and Vocational Relationships in Practical Nursing by Carmen F. Ross, R.N., M.A. 208 pages. J. B. Lippincott Company, 4865 Western Avenue, Montreal. 1961. Price \$1.95.

This is a text written especially for the nursing assistant with the aim of helping her to adjust satisfactorily.

The range of topics includes the history of nursing; the nursing team; attitudes; personal considerations; ethical and legal responsibilities. Considerable detail is given under each main heading. For example, in discussing the nursing team, the author gives a careful definition of nursing; indicates the functions of the nursing auxiliary in detail and her relationship to other members on the team; discusses educational programs for the nursing assistant and her legal standing; briefly defines nursing care patterns such as the functional method; total patient care; progressive patient care, etc.

This is an American text and some of the material presented will not be applicable to the Canadian situation, particularly in relation to educational standards and qualifications for licensure.

Preventive Procedures for Combating Cross-Infection. H. P. Curley. 32 pages, 1961. Research Department, Hospital Bureau Inc., 60 West 55th Street, New York 19, N.Y. 2nd ed. Price \$2.00.

First published in 1959, the information in this edition has been partially or completely revised to provide the most authentic and authoritative views on many nursing, housekeeping, central supply and laundering procedures and techniques associated with cross-infection. The aim is to rid the hospital environment of infectious organisms. The data are applicable to hospitals of any size. There is a very extensive list of articles for reference purposes.

This booklet is a *must* for every hospital.

Sources for Hospital Administrators. Publications and Facilities Serving the Health Administration Field. By Paul Wasserman. 60 pages. Publications Section, Graduate School of Business and Public Administration, Cornell University, Ithaca, N.Y. 1961. Price \$2.00.

An annotated bibliography of information facilities for hospital administration and related disciplines.

"Sudden death," even from a massive heart attack or from shock on the operating table, is not really *sudden*. After the heart stops, there may be a few last, shallow breaths. The brain lives on for five or six minutes, and perhaps longer under some conditions. In Moscow, at the Fifth International Congress on Biochemistry, Soviet investigators, reported new findings about the dying brain, and new means of bringing the "dead" back to life. Dr. Maria Gaievskaya described methods developed in Dr. Vladimir Negovsky's resuscitation laboratory in Moscow. The laboratory is already famous for its success in reviving thousands of suffocation victims, a number of heart attack victims and stillborn babies by pumping blood bank blood into arteries under pressure during the six minutes after "clinical death." Dr. Gaievskaya's findings offer an explanation of that six minutes of grace.

Autopsies, after resuscitation has been tried, often show that brain cells have been irreparably damaged. It has been assumed that this damage resulted simply from oxy-

gen starvation. The Negovsky laboratory has found that the cause of the damage may have been *too much* oxygen. According to Gaievskaya theory, when heart stoppage cuts off the blood supply, the brain can no longer get oxygen to burn sugar for its energy. It switches to a cruder, less efficient way of breaking down sugar without blood-borne oxygen (anaerobic glycolysis) to extract whatever energy it can. This emergency system will work for about six minutes. If the body is revived during this time, the brain makes a gradual transition, occupying about half an hour, back to using oxygen. A critical aspect of this process is to avoid flooding the brain with oxygen. If resuscitation is begun within six minutes, so that oxygenated blood resumes its flow to the brain, the switchover from anaerobic glycolysis will be gradual and must not be rushed. Extra oxygen given too soon may damage the brain as surely as the lack of oxygen ultimately does in normal death.

— Adapted from *Time*, August 25, 1961

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Registered Nurses for 30-bed General Hospital, 50 mi. from centre of Montreal, excellent bus service. Starting salary \$275 per mo., 3 semi-annual increases, 40-hr. wk. 4-wk. annual vacation, statutory holidays, 2-wk. sick leave, Blue Cross paid, living accommodation available. Apply: Mrs. D. Hawley, R.N., County Hospital, Huntingdon, Quebec.

U.S.A.

Registered Nurses for modern 374-bed JCAH fully accredited General Hospital. Located on beautiful San Francisco Peninsula, 20-min. drive from the heart of the city. Openings in all services. Excellent personnel policies. Many extra benefits & opportunities for advancement. Top salaries. Apply: Personnel Director, Peninsula Hospital, 1783 El Camino Real, Burlingame, California.

Registered Nurses (eligible for California registration) for new 254-bed JCAH approved district hospital, San Francisco Bay area. Positions available in surgery, Gyn. O.B., pediatrics & medicine. **Staff Nurses** entrance salary \$360 with range to \$420 per mo. Supervisory positions at increased rate. Special area & evening differential paid. Free Blue Cross hospitalization & surgical coverage with liberal personnel policies & fringe benefits. Uniforms laundered free. Excellent modern housing, schools & colleges. Apply: Director of Nursing, Eden Hospital, 20103 Lake Chabot Road, Castro Valley, California.

Registered Nurses (Come to sunny California) **Staff Nurses for permanent positions**, various departments, days, evens., nights. Excellent starting salary, increments, benefits & working conditions in one of the largest & finest general hospitals in the West. For details write: Personnel Department, Queen of Angels Hospital, 2301 Bellevue Avenue, Los Angeles 26, California.

Registered Nurses: Expansion has created excellent opportunities for the new employee who wishes to progress in the field of nursing, our 525-bed General Hospital offers experience in all occupational specialties including psychiatric nursing. Starting salaries, **General Duty** \$390 per mo. days; \$415 per mo. P.M. & nights; \$10 differential per mo. for psychiatry; **Operating Room** \$415 per mo. days; \$440 P.M. & nights. Its location, in the heart of California, affords a pleasant climate & easy access to all summer & winter recreational activities. Liberal employment benefits, including pd. holidays, paid vacation, paid sick leave, free hospitalization insurance, retirement plan, etc., Write: Personnel Dept., Sutter Community Hospitals, 2820 - L Streets, Sacramento, California.

Registered Nurses for private 258-bed hospital for men, women & children. Staff Nurse salaries from \$345 - \$415, differentials for evenings, nights, communicable disease, operating room & delivery. Opportunities in all clinical areas. Holidays, vacations, sick leave & health insurance. California registration required. Applications & details furnished on request. Contact: Personnel Director, Children's Hospital, 3700 California Street, San Francisco 18, California.

Registered Nurses General Duty for 230-bed approved teaching hospital, resort city. Starting salary \$350 plus \$22.50 shift differential, provision for housing allowance. Apply: Director of Nursing, Cottage Hospital, Santa Barbara, California.

Registered Nurse for general night duty at West Side Community Hospital District. Starting salary \$350, full time duty, 7 paid holidays, 2-wk. vacation with pay, hospital insurance, room & board available if desired. Contact Mrs. Doris Elholm, Administrator, 151 So. Highway 33, Newman, California.

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Staff Nurses for new modern 800-bed General & Tuberculosis Institution in beautiful San Joaquin Valley city - no smog - no snow - 235,000 in metro. area, midway between Los Angeles & San Francisco, close to 3 National Parks, 2 colleges & other cultural advantages. Full maintenance available. Immediate appointment. \$4,320 to \$5,400 per year. Apply immediately to: Director of Personnel, Fresno County Civil Service, Room 101, Hall of Records Building, Fresno 21, California.

Staff Nurses for 300-bed General Hospital. Attractive personnel policies plus differential for specialties, afternoon & night duty. Opportunities for advanced education. Apply to: Director of Nursing Service, Kaiser Foundation Hospital, Oakland 11, California.

Staff Duty positions in private 428-bed hospital, non-registered graduates acceptable. Liberal personnel policies & salary. Write to: Personnel Director, Hospital of the Good Samaritan, 1212 Shatto Street, Los Angeles 17, California.

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Registered Nurses for 200-bed General Hospital located in beautiful suburban residential area on Lake Michigan, 30-min. from Chicago. Base salary \$380, differential of \$20 for nights, \$30 for evenings. Live in modern nurses' bungalows adjacent to hospital & enjoy social, cultural & educational advantages of Chicago. Recent completion of new building creates opportunities in all clinical services, liberal personnel benefits include free retirement program. Contact: Director of Nursing, Highland Park Hospital, Highland Park, Illinois.

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Staff Nurses (All Clinical Services) Base salary \$319, differential for 3-11 and 11-7 shifts, liberal personnel policies include sick leave, retirement plan, 3-wks. vacation & laundry of uniforms. Orientation & in-service programs — housing available on campus or in vicinity of hospitals. Apply: Director of Nursing Service, The University of Texas-Medical Branch Hospitals, Galveston, Texas.

General Duty & O.R. Nurses for 210-bed General Hospital, start—days \$355-\$395, evenings \$380-\$420, nights \$375-\$415. O.R. starts \$385. University city, postgraduate study at 2 universities, 40-hr. wk., 7 holidays, vacation, sick leave benefits, free Blue Cross hospital-medical insurance & \$1,000 life insurance. Retirement program, extensive Intern-Resident educational program, living quarters available. Write: Personnel Manager, Virginia Mason Hospital, 1111 Terry Avenue, Seattle 1, Washington, 'Come to the Seattle World's Fair April 21 - October 21, 1962.

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General Duty Nurses for 200-bed General Hospital with School of Nursing. Salary range \$297 to \$359. Pre-planned shift rotation, B.C. registration essential, 4-wk vacation after 1-yr. Apply: Director of Nursing, Royal Inland Hospital, Kamloops, British Columbia.

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General Duty Nurses, Saskatchewan registered, for 100-bed General Hospital. Salary based on experience, with recognition for P.G. Courses & University training. Good personnel policies. Residence accommodation & meals if desired. Apply to: Director of Nurses, Union Hospital, Weyburn, Saskatchewan.

U.S.A.

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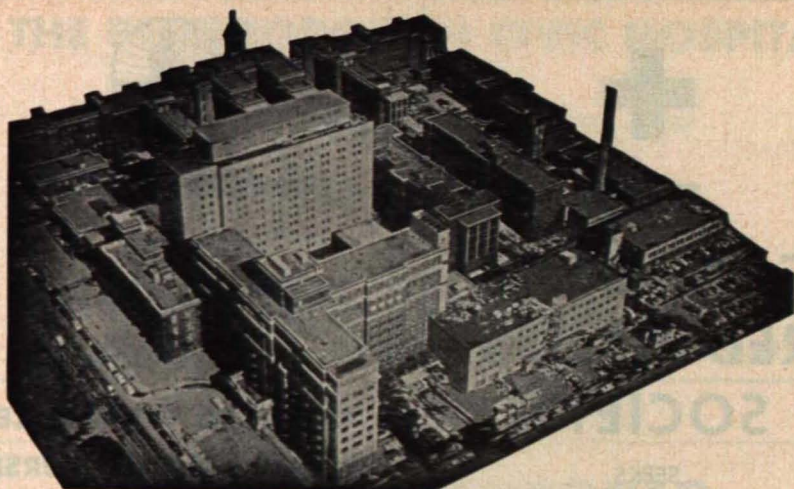
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Positions available for:

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Basic salary \$285 — \$325 per month with Ontario registration.

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Vacation - 18 days plus 10 statutory holidays a year, 21 days sick leave cumulative from time of employment.

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Vancouver Island.

Apply with record of experience, training
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Friendly hospital and community

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Position will be open on
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44-bed hospital with expansion
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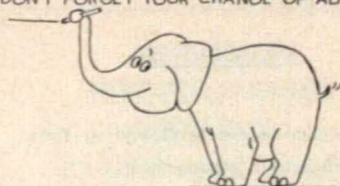
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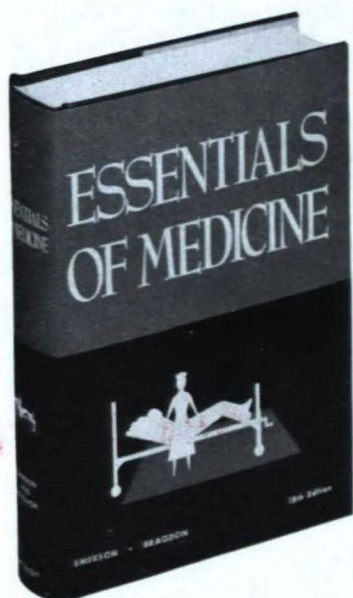
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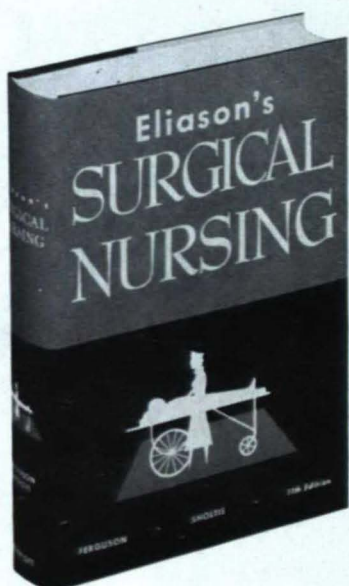
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